AGENDA NOTES

FIFTH CONFERENCE OF CENTRAL COUNCIL OF HEALTH & FAMILY WELFARE

PARLIAMENT HOUSE ANNEXE
JANUARY 8-10 , 1997

GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
NEW DELHI

2/2/97

AGENDA NOTES

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Dental Problems: National average 11.13%. 20 States/UTs are above the national average.

The programmatic implications of this data will require an indepth analysis after the detailed data from all districts is received. However, States were advised to initiate action in the following areas immediately;

a) The problems like anaemia, dental carries, worm infestation, night blindness and scabies are preventable. Activities like health education with emphasis on personal and food hygiene have to be taken up immediately by the States. Role of teachers who were involved in the programme becomes important in this activity and they have to be involved with the help of material on prevention included in the training manual.

b) The interventions at field level will have to be State specific and within the States also the district wise incidence will have to be taken into account before deciding the same. States have been requested to analyse the district/PHC wise data and institute immediate correctives for stepping up Vitamin A and anaemia prophylaxis as these form a part of CSSM Programme.

The States had to ensure that the referral system was put into place by the States for taking care of the referrals emanating as a result of the school health check up. Medical Officers have to keep a proper record of the referrals so that their findings can be used to corroborate the findings of the health check up done by the health workers. Monitoring system for cases referred to specialists also had to be put into place.

The initial feed back from the States during the visits of the officers suggests that training of health workers and teachers was not uniform in all districts even in

signal step for promotion of mother and child health. However, the Act did not bring the desired results because of age old traditions and social pressures. To improve social attitudes, all out efforts are needed to increase the level of consciousness about the bad effects of early marriage on the health of both mother and the child and its impact on the population of the country. For this it is necessary to:-

(I) Raise societal consciousness against the marriage at an early age,

(ii) Effective implementation of the Child Marriage Restraint Act; and

(iii) Delay the first birth. It is essential that States improve the delivery of this message through different channels of communications on consequence of early births and methods for preventing the same. It is desirable to:

(a) Launch intensified inter-personal communication campaigns for communicating the message on the advantages of marriage at a ripe age for the health of both the mother and the child and methods for preventing early births.

(b) NGOs and local bodies can also be effectively involved in this movement.

(c) Organisations like Nehru Yuvak Kendras, Mahila Swasthya Sanghs, NSS and Bharat Scouts and Guides could also be involved in this campaign.

(d) Mass Media including electronic, print and traditional ones can be made effective use of.

(e) Preferential treatment under the various development programmes to those beneficiaries who conform to these norms can also be considered.

(f) Sensitisation of social and religions opinion leaders should be taken up actively to promote marriages at higher age.

(g) Doordarshan (National and regional level) may be persuaded to give five minutes free time daily during prime times for socially relevant messages on family welfare and compulsory registration of marriages.

Agenda Item No. VI

STRENGTHENING OF PRIMARY, SECONDARY & TERTIARY HEALTH CARE DELIVERY SYSTEM IN COMPLIANCE OF ORDER OF HON'BLE SUPREME COURT MAY, 1996

The Common Minimum Programme:

As per the Common Minimum Programme 100% coverage of Primary Health Service facility in rural and urban areas is to be ensured. We have at present a service facility at the level of 5000 rural population named as Sub-Centre This is staffed by one male and one female paramedical staff. A Sub-Centre is most peripheral contact point between the Primary Health Care system and the community. On an average six Sub-Centres are supervised and supported by a Primary Health Centre headed by Medical Officer and supportive staff. For specialist's services patients are referred to the Community Health Centre which functions as a referral institution for in proximity to Primary Health Centres.

As on 30.06.1996, there are 132730 Sub-Centres, 21845 PHCs and 2424 CHCs functioning in the country.

REVISION OF FUNDING AND STAFFING PATTERN FOR CENTRAL ASSISTANCE TO STATE FOR IMPROVING RURAL HEALTH SERVICES.

A review of funding and staffing pattern for Central assistance to States is needed to improve rural health services.

Suggestions for the same are placed as a background material for discussion(Annexure A).

STRENGTHENING OF PRIMARY HEALTH CARE SERVICES AT 5000 POPULATION LEVELS.

(I) Establishment of adequate number of Sub-Centres as per the population coverage norms in vogue. Ignoring the States with surplus health infrastructure, it is estimated that our country as on 30.6.96 would need an additional number of 10081 Sub-Centres, 2003 PHCs and 3133 CHCs to meet the norms for population coverage as per 1991 population.

(ii) Provision of Safe Delivery Room (APNA GHAR) under Employment Assurance Scheme of Ministry of Rural Development which can also act as a meeting place for women's group for promotional activities.(Annexure B)

(iii) Community participation

The involvement of individuals, families and communities in promotion of their own health and welfare, is an essential ingredient of primary Health Care. Therefore, there must be a continuing effort to secure meaningful involvement of the community in planning, implementation and maintenance of health services, besides maximum reliance on local resources such as manpower, money and materials including indigenous system of medicine, if any, being practised in the region. A concept paper prepared by the Ministry of Health & Family Welfare is enclosed as Annexure C.

(iv) Training of Heath Volunteers and Dais etc.

The programme aims at providing training to all the practising Traditional Birth Attendants(Dais) in rural areas to enable them to conduct safe delivery besides training volunteers from the community to act as Village Health Volunteers. As on 1.4.1996 there are 660996 trained Dais ad 410904 trained Village Health Guides in the rural areas.

ANNEXURE A

REVIEW OF PATTERN OF STAFFING AND CENTRAL ASSISTANCE TO STATES IN THE NINTH FIVE YEAR PLAN

I. STAFFING PATTERN:

a) Sub-Centre:

It is presently staffed by an ANM, a Multipurpose Worker(Male) and a part-time helper.

It is recommended that an additional ANM be provided for sub-centres located in remote, hilly and tribal areas and in poor performing districts.

b) Primary Health Centres: Staffing pattern be modified to ensure institutional deliveries at the PHCs.

c) Community Health Centres:

Staffing pattern be modified to ensure its functioning as a First Referral Unit capable of managing obstetric and other emergencies. Posting of an anaesthetist and Gynaecologist and a Paediatrician be ensured so that Reproductive and Child Health Services are delivered effectively.

II. PATTERN OF CENTRAL ASSISTANCE TO STATES

The pattern of Central assistance to States was approved sometimes in 1980-81. There have been many suggestions from the State Governments for upward revision of the ceilings fixed as prices have gone up during the last 14-15 years. Keeping in view the price escalation and other factors, the following revised pattern is suggested.

1. Sub-Centre

	Existing	Revised	Total addl. Expenditure
Non-recurring	Rs. 3200	Rs. 5000	Depending on the Sanction for the opening of new Sub-centres.
Recurring			
Salary of ANM as per State Govt.	--	--	The existing expenditure will vary from Time to time.
Helper	Rs. 600/-p.a.		Rs. 1200/-p.a.
Contingency	Rs. 600/-p.a.	Rs. 1400/-p.a.	
Rent(if Sub-Centre is in Rented building.)	Rs. 1000/-p.a.	Rs. 3000/-p.a.	
Salary of LHV(1 LHV for 6 SCs)	As per State Govt Scale of Pay		expenditure will vary from time to time
Medicine	Rs. 2000/-p.a.	Rs. 5000/-p.a.	

Apart from salaries on ANM, LHV the proposed cost per unit(recurring) will be 10700+revised salary of ANM+LHV(1/6th) as per State Government Rates.

2. Training of ANM/LHV

There are 464 ANM(Female Health Workers) Training Centres with an admission capacity of 21486 out of which 382 are funded by Government. Of India. There are 44 promotional LHV Training Centres with an admission capacity of 2718 functioning in the country. These training institutions are imparting training to prepare the required number of ANMs and LHVs to man the Sub-centres, Primary Health Centres, Community Health Centres, Rural Family Welfare Training Centres

and Health Courses in the country. The existing pattern of Central Assistance is as under:-

1. Recurring

I. Staff(for admission capacity of 40)

-Principal Nursing Officer	1
-Sister Tutor	2
-Public Health Nurse	4
-Senior Sanitary Inspector	1
-U.D. Clerk	1
-Domestic Staff	6
-Warden	1

ii)Stipend Rs. 125/- per month per trainee.

iii)Contingency Rs. 5000/- per anum

iv) POL As per approved norm for Family Welfare vehicle.

v) Rent for school and hostel building Rs. 2500/-
(If it is functioning in rented building)

The pattern of assistance was fixed in 1978. The prices have gone up during the last 12-13 years. Keeping in view the price escalation and other factors, the following revised pattern is suggested:-

1. Recurring	Existing	Revised	Existing Exp.
I) Staff(for admission capacity of (40)			
Principal Nursing Officer	1		
Sister Tutor	2	As per	The expenditure
Public Health Nurse	1	State	will vary from
Senior Sanitary Inspector	1	Govt.	Time to time
U.D. Clerk	1		
Domestic Staff	6		
ii) Stipend	125/-	300/-	

iii) Continency	5000/-	10,000/-
iv) POL	As per admissible rates needs to be revised.	
v) Rent of school and hostel building(if it is functioning in rented building.)	2500/-	5000/-

3. Scheme of Training of MPW(Male)

This scheme was started during 6th Five Year Plan in the year 1982. At present, it provides free service of basic training of 1 year duration. On successful completion of the training, the Health Workers(M) is posted at a Sub-centre along with a Health Worker(F). There are 65 MPW(M) Training Centres which are functioning in the country as on 1.4.96. Of these, 36 Health and Family Welfare Centres are imparting basic training to MPW(M) and there are 29 basic MPW(M) schools. The existing pattern of assistance was fixed in 1984. Due to escalation of prices, the revised pattern of assistance is suggested.

1. Non-recurring	Existing	Revised	Existing Exp.
I) Equipment and Furniture for schools	@ Rs. 75,000/-per school with Annual admission capacity of 60 candidates		New schools not sanctioned
ii) Furniture, utensils etc. For Hostel	@Rs. 1500/- per seat Rs. 90,000/- for 60 Candidates		
II. Recurring			
I. Rent or Schools	Not exceeding Rs. 5000/- per month		Rs.10,000/-
ii) Rent for hostel	@Rs. 125 per month per		

	Candidate in lieu of non-availability of hostel.	
iii) Stipend for trainee.	@Rs.125/- per month per Candidate, i.e. Rs. 90000/- for 60 candidates.	Rs. 300/-
iv) Education aids,training Material for training Like models, flip charts etc.	Rs. 5,000/-p.a.	Rs. 15,000
v) Transportation(for Hiring bus)	Rs. 15,000 per school	Rs. 30,000
vi) Contingency	@Rs. 15,000/-p.a.	Rs. 30,000
vii)Pay & allowance of staff	As per pay scales of State Govt.	Will vary from time to time.

Apart from the increase of salary of the staff, the proposed cost per unit will be Rs. 3,10,000/-.

4. Health & Family Welfare Training Centres

There are 47 Health & Family Welfare Training Centres established in the country to impart in-service training to the staff working at the sub-centres and Primary Health Centres.These training centres were set up with 100% financial assistance by the Central Govt. Under the Family Welfare Programme. The existing pattern of assistance as also the revised pattern, necessitated by the price escalation and other factors as under:

Non-recurring	Existing	Revised
1. Vehicles(one bus, one mini bus & One jeep or two mini-bus & one jeep) & equipment including duplicating Machine projector, typewriter and Furniture.	Rs. 1,36,500/ (old expenditure) as no training centre has been sanctioned after 1978.	Actual cost of vehicle

2. Construction	Cost of 20350-20450 Sq.ft. Plinth Area as per the blue print of GOI.	As per approved rates by CPWD/PWD
Recurring per annum		
3. Pay and allowances etc.of Staff(as per pattern)	As per State Govt's Pay scale.	As per State Govt. Pay scale.
4. Contingencies including purchase of educational materials books for library, periodicals, postage, telephone charges, electricity and stationery and other charges.	Rs. 6,000/-p.a.	Rs. 15,000
5. Cost of petrol and maintenance of Vehicles@Rs. 12,000 and Rs. 9,000 (Petrol and Diesel reported driven vehicles)	(Revised from time to time) Rs. 36,000/-	Revised from time to time
6. Rent for training centre and hostel for trainees in case Govt. accommodation is not available.	Rs. 18,000/-p.a.	Rs. 40000
7. Payment of Guest Faculty	Rs. 1500/-	Rs. 5000

The proposed cost per unit will be Rs. 60,000/-

ANNEXURE B

MULTI-PURPOSE 'APNA GHAR' MOTHER AND CHILD HEALTH CARE CENTRE IN VILLAGE UNDER JAWAHAR ROJGAR YOJNA OF GOVERNMENT OF INDIA

In order to provide on the spot quality ante-natal, natal and post-natal care to the pregnant women and new born, provision is being made under Jawahar Rojgar Yojna(JRY) to construct a low cost room in every village.

2. Location

The room will be constructed within the village habitation using locally available suitable material blending with the architecture and local materials from one village.

3. Construction

The room will be constructed by the Panchayat. Alternatively Mahila Mandals could be commissioned and they could employ contractors for this.

4. Upkeep

The upkeep of the room should be handled by community participation. Ideally women's groups would be best suited for raising necessary contribution in cash and in kind for this activity.

5. Utilisation

The room would be used for multiple purpose.

(I) Ante-natal, natal and post natal care to the pregnant women and new born.

(ii) Acceptors for users for Family Planning programme specially IUD insertion.

(iii) Immunisation programme.

(iv) Nutrition programmes under ICDS and

(v) Mahila Mandal meeting for which adjacent arrangements will be incorporated.

(vi) Screening for RTI/STD and organising referral.

6. Design of the room:

The room within an area of approximately 200 sq.feet will have two masonory platforms for mother, counter top for the baby and trugh for the hand wash. The sanitary Sulabh water borne latrine will be built adjacent to the room but with access from outside thus keeping the labour area clean. The liquid based waste will be disposed off in the latrine whereas the placenta waste will be buried in the fields away from the room or as per local practice. A kitchen will be incorporated for Anganwaris under ICDS programme who need to rent the place. This will be in consultation with Department of Women and Child.

This being a multi use centre, efforts are being proposed to make the structure used as continuously as possible so that it is properly looked after, maintained and becomes functional for the benefit of mother and child health of village.

ANNEXURE C

Community Involvement in Primary Health Care at 5,000 Population

Community involvement is a very complex social process and it requires strong commitment, planning, sincerity of purpose and guidance at various levels both in Govt. and community. Primary Health Care is essential health care made universally accessible to individuals and acceptable to them through their participation and at a cost the community and the country can afford. The concept of Primary Health Care has been accepted by all the countries as the key to attainment of Health for All by 2000 AD. Community participation is one of the basic principles of Primary Health Care. Notwithstanding the overall responsibility of the Central and the State Governments, the involvement of individuals, families and community in promotion of their own health and welfare is an essential ingredient of Primary Health Care.

Community involvement flows more naturally with provision for recognition, sense of accomplishment, provision for community reward i.e. linking opening of schools, roads, provision of hand pump etc. for the village and other schemes. These would automatically lead to a sense of ownership and partnership in schemes meant for the people. The capacity of individuals and families could thus be enhanced through such involvement in planning, implementation and maintenance of health services as direct benefits can be seen from their own efforts.

Mobilisation and Organisation of Community at Village level.

To enable community village level structures to be established, existing women's groups like Mahila Swasthya Sanghs, Mahila Samakhyas, Mahila Kosh,

Indira Mahila Yojna, Youth Mandals and Ex-servicemen groups, Mothers groups etc. can be networked. Clusters and hamlets can be represented by volunteers. These groups could be mobilised and organised to work together for the improvement in health seeking behaviour. Where only one or two groups of the above mentioned category are available the expected functions of the other groups, as established under Women and Child development, Education, Rural Development etc. could be taken over by the group currently existing in the village.

The activities of this village level structure would be:

1) Keeping the Village Water Points Clean.
2) Ensuring village Health Sanitation.
3) Ensuring provision of service for common illness.
4) Inter-acting between service providers and community.
5) In case of outbreaks of diseases to organise village level control activities through health providers.
6) Controlling vaccine preventable diseases and assisting in immunisation services.
7) Mother and Child Health, Anti-natal Care, Post-natal care, Nutrition, Counselling, Family Planning etc.
8) Health Education and preventive and promotive services.

Planning

The above organised community groups will plan their activities for health action twice a year after Rabi and Khariff seasons i.e. in June or December or in any other months as may be convenient to them in view of their agricultural activities and season ability of health problems. The initial meeting for planning of activities would be attended by Government functionaries like ANMs, Anganwadi Workers, Multi-purpose Workers, Block Extension Educators, Village Chowkidars,

Ex-servicemen and NGOs. These Government officials will provide all information about official health programmes and necessary coordination and help to convene various activities in the community. These groups will also hold monthly meetings for review of various community activities. Govt. functionaries will also participate in monthly meetings as far as possible. Medical Officer of PHC will also participate in planning meetings as far as possible.

Community Training in various Health Programmes

The members of the community will be regularly trained in various health programmes and new initiatives taken up by the Government of India so as to seek their active participation.

Venue of a Meeting

Every village should identify a room either constructed by Govt./Panchayat or donated by local community. These rooms will serve the purpose of delivery of health services like Mother and child health, Immunisation etc. and for the meetings of the village groups. Till such time this room becomes available, these group activities of the community would be carried out in a room to be provided by the Panchayat.

Agenda Item No. VII

ALL INDIA HOSPITALS POST PARTUM PROGRAMME,URBAN FAMILY WELFARE CENTRES AND URBAN REVAMPING SCHEME AND RURAL FAMILY WELFARE CENTRES.

At present 550 Post Partum Centres are functioning at District Level and 1012 at Subdistrict Level. In addition 1083 Urban Family Welfare Centres, 871 Health Posts and 5435 Rural Family Welfare Centres are functioning in the country. State-wise and scheme-wise distribution of these Centres is given in Annexure - I.

The achievement of these Family Welfare Schemes need to be made result oriented. It is proposed that grant-in-aid in respect of the above Schemes may be frozen at the 1996-97 level. However, additional grant in aid of 10% be given to those States which record at least a 5% reduction in Birth Rate and I.M.R. The additional grant in aid will be made available after the relevant SRS figures are available.

ANNEXURE-I

Statement showing State-wise number of Post Partum Centres, Urban Family Welfare Centres, Urban Health Posts and Rural Family Welfare Centres

Sl. No.	State/Union Territory	Number of Units				
		Post Partum Centres		Urban FW Centres	Health Posts	Rural FW Centres
		District	Subdistrict			
1.	Andhra Pradesh	28	55	131	--	420
2.	Arunachal Pradesh	--	1	6	--	--
3.	Assam	11	30	10	--	146
4.	Bihar	37	54	42	--	587
5.	Goa	4	--	--	--	13
6.	Gujarat	33	55	113	28	251
7.	Haryana	13	20	19	16	89
8.	Himachal Pradesh	11	22	89*	--	77
9.	Jammu & Kashmir	11	6	12*	--	82
10.	Karnataka	39	64	87	--	269
11.	Kerala	22	60	--	--	163
12.	Madhya Pradesh	47	75	63	99	460
13.	Maharashtra	52	69	74	278	428
14.	Manipur	3	1	2	--	31
15.	Meghalaya	3	1	1	--	23
16.	Mizoram	2	4	1	--	14
17.	Nagaland	1	1	--	--	7
18.	Orissa	19	60	10	8	314
19.	Punjab	19	35	23	64	129
20.	Rajasthan	35	100	61	90	232
21.	Sikkim	1	2	1	--	15
22.	Tamil Nadu	32	87	65	100	383
23.	Tripura	1	3	9	--	35
24.	Uttar Pradesh	72	147	81	150	907
25.	West Bengal	27	55	111	--	335
26.	A & N Islands	1	--	--	--	--
27.	Chandigarh	2	--	3	10	1
28.	D & N Haveli	--	--	--	--	--
29.	Daman & Diu	--	--	--	--	--
30.	Delhi	9	5	69	28	8
31.	Lakshadweep	--	--	--	--	--
32.	Pondicherry	3	--	--	--	12
33.	Central Sector	12	--	--	--	--
	Total:	550	1012	1083	871	5435

*: Reconciled figures not received.

Agenda Item No.VIII

INCENTIVES AND DISINCENTIVES RECOMMENDED IN THE REPORT OF THE COMMITTEE ON POPULATION OF THE NATIONAL DEVELOPMENT COUNCIL.

The Committee on Population of the National Development Council (NDC) had, in its Report, recommended a number of incentives and disincentives, both for the general public and for Government./semi-Government. employees. This Report was endorsed by the NDC in its 46th meeting held in September, 1993. An extract of the relevant recommendations, contained in paragraphs 5.17 to 5.17.8 and 5.18 of the said Report, is given below :

The incentives/disincentives currently applicable to employees of Central/State/UT Governments, Autonomous Bodies, Public Sector Undertakings etc. for adopting small family norm may be appropriately modified as follows :

Leave Travel Concessions, free or concessional rail/bus or air jouneys wherever applicable, CGHS facilities/reimbursement of medical expenses, Maternity Leave benefit (excluding those directly affecting the health of the pregnant mother and the foetus/new born), etc. are made available up to two children only.

Special increments for undergoing sterilisation, incentive of lower rate of interest for house building advances, interest bearing advances viz. vehicle loans should be available to the employees with two or less children only.

Priority in allotment of Government accommodation is given to employees who have adopted 2-child norm.

Any public servant violating the Child Marriage Restraint Act or who has more than 2 children should be debarred from promotion for a period of five years and birth of a child beyond three should result in dismissal from service.

Persons violating the Child Marriage Restraint Act or having more than 2 children may be debarred from recruitment in the Government/Autonomous Bodies/ Public Sector Undertakings.

Legal and administrative implications of the above recommendations should be got examined before implementation, once these are accepted in principle by the Government.

Regarding incentives available under the compensation of loss of wages to the acceptors of sterilisation the States/UTs may be given flexibility of operation.

Special incentives and support to such programmes as involvement and continuation of schooling of female children, delaying the age at marriage, old age pensions as already adopted by several States should be introduced in other States also.

Benefit of loans, advances, allotment of land/house sites, facilities of PDS should be withdrawn from families violating the 2-child norm but may be restored after the couple has undergone sterilisation operations.

Amendment to Panchayati Raj Act brought by the Rajasthan Government is recommended to be emulated. The Central/State Governments should consider bringing similar legislation for disqualifying the peoples' representatives at different levels if they violate small family norm after getting elected Such a step would have useful demonstration effect on the people at large.

In pursuance of another recommendation of the Committee on Population of the NDC, the Department of Family Welfare constituted a Group of Experts to prepare a preliminary draft of the National Population Policy. In its Report, this Group of Experts recommended that " Incentives in cash or kind given by the Central and State Governments for the acceptors of contraceptives as well as motivators and service providers will be discontinued." In regard to employees in the organised sector (Central Government./State Government./ Local bodies/ Public Sector) this group recommended modification of service rules and promotion policies to ensure that the small family norm is adopted by their employees. This Group recommended that persons who marry below the legal minimum age of marriage be debarred from recruitment. The private organised sector was also urged in this Report to take similar steps.

Currently, the Central Govt. does not have any scheme of incentives linked to adoption of terminal contraception, or of the small family norm for the general public. There exists a scheme of "Cash Compensation for Acceptors of Sterilization and IUD Insertion." Under this scheme, an amount of Rs.200/180/16 is given to the State or Union Territory for every case of tubectomy/vasectomy/IUD insertion performed. The entire amount in the case of IUD insertions and about half of the amount in the case of sterilisations goes to defray the cost of the surgical procedure. In accordance with recommendation No. 5.17.6 of the Committee on Population of the NDC, States/UTs have been given flexibility of operation, from the year 1996-97, to apportion the total amount between various items of expenditure, subject to a few restrictions. Reports received from States/UTs indicate that they are continuing to give a cash payment of about Rs.100/- per case of sterilisation to the acceptor, and also incentives to motivators and service providers. The payment to the acceptor is conceptually not an incentive. It is intended to compensate the acceptor for wages lost in the process of undergoing sterilisation.

On account of inflation, this amount of about Rs.100/- per case has no value as an incentive, and is inadequate even to compensate for wages lost. Non-disbursement of this amount to the acceptor or delayed disbursement are strong possibilities. Keeping these factors in view, the States/UTs were urged to phase out cash payments to acceptors, motivators and to Government. Sector service providers, while giving them flexibility in operation of the above mentioned scheme.

Incentives do, however, exist for Central Government employees who (or their spouses) undergo sterilisation after one, two or three children. States/UTs and public sector undertakings have generally allowed these or similar incentives to their employees. These incentives are as follows :

- A special increment in the form of personal pay not to be absorbed in future increases of pay.
- Rebate of 1/2% on interest on House Building Advance.
- Special casual leave for undergoing sterilisation.

There are no disincentives, except a restriction of two living children on eligibility for maternity leave, for female Government. employees.

Several States/UTs have introduced schemes of incentives, from their own funds, for the general public. Such incentives are linked either to acceptance of terminal contraception (sterilisation), or linked to education of female children, delaying marriage of girls etc. The Department of Family Welfare has introduced a 'Community Award Scheme', on pilot basis, in the year 1996-97.

International thinking on the subject is reflected in para 7.12 of the Programme of Action of the International Conference on Population and Development (ICPD), 1994; the relevant portion of which is reproduced below :

"Any form of coercion has no part to play. In every society there are many social and economic incentives and disincentives that affect individual decisions about child-bearing and family size. Over the past century, many Governments have experimented with such schemes, including specific incentives and disincentives, in order to lower or raise fertility. Most such schemes have had only marginal impact on fertility and in some cases have been counterproductive."

With an ongoing constraint of resources, any policy of incentives linked to adoption of contraception is not likely to be sustainable. Incentives/disincentives are also contrary to the tenet of voluntary and informed choice.

The Department of Family Welfare proposes the following policy formulation for consideration by the Central Council of Health and Family Welfare on the issue of incentives and disincentives.

Incentives

Incentives in cash or kind given by the Central and State Governments for the acceptors of contraception as well as to motivators and service providers will be discontinued in a time-bound manner. Community incentives aimed at encouraging the community to undertake activities resulting in reduction of birth rate, infant and maternal mortality rates, increase in female literacy, increasing the age of girls at marriage etc. have been introduced. The possibility of introducing income tax concessions, in the form of higher tax exemption limit or in other forms will be examined. Innovative schemes specifically directed to improve the status of the girl child and eliminating adverse sex ratio would be developed. Special attention will be given to the areas and States having a high TFR and IMR.

Organised Sector

The employees of the Central Government, State Governments, Municipalities, and employees of various public sector undertakings must give the lead in adopting the two child norm. The service rules in the Central and State Governments and their undertakings would be suitably modified to ensure that the two child norm is adopted by their employees. Similarly, all new entrants to the government who are married before the legal age of marriage will be debarred from recruitment. Promotion policies should be such that the adoption of the two child norm is encouraged. The entire organised sector (public as well as private) must also take similar steps in order to create an environment where the two child norm is adopted by these relatively better off classes of society."

In accordance with para 5.18 of the Report of the Committee on Population of the NDC, the Department of Family Welfare has introduced the Constitution (Seventy-Ninth Amendment) Bill in Rajya Sabha, in the year 1992. This Bill seeks to amend the Directive Principles of State Policy to provide that the State shall endeavour to promote population control and to include in the Fundamental Duties, a duty to promote and adopt the small family norm. It also proposes to disqualify persons from being chosen as or holding office as, a member of either House of Parliament or State Legislative, if he has more than two children. The proposed amendment will have prospective effect only, in regard to the disqualification for elective office. This Bill has been recommended for passage, without any changes, by the Parliamentary Standing Committee on Human Resource Development. By virtue of Articles 243F(1) and 243V(1) of the Constitution of India, these restrictions will apply to elective offices in Panchayats and Municipalities also.

Agenda Item No.IX

REVIEW OF PREPARATION OF DISTRICT TRAINING PLANS WITH SPECIAL EMPHASIS ON TRAINING OF ANMs AS TRAINERS OF DAIS

Training Systems/Planning at District Level with Support from State/Centre

Well developed training systems has to be evolved to take up training as an ongoing and sustained activity. This is particularly critical as the current method of conducting ad-hoc training under the different components of Family Welfare have neither been cost effective nor have they brought about the desired behavioural and attitudinal change in service providers.

Planning and Implementation of In-service Training at the District Level

This training has thus to be seen as a responsibility of the district administration. The district must ensure that all personnel are exposed to the training programmes at regular specified intervals. Since the responsibility of arranging for the training would be at the district level, stress will be laid on capacity building at the district itself to train peripheral health providers. The district would need to adhere to the uniform package of training but will have sufficient flexibility to take into consideration their own training needs and particular conditions.

The initial training at the district may not be sufficient for required skill development e.g. I.U.D. insertions, sterilization operations, and delivery cases. This may require placement of the trainees to different health facilities at a later date. To

ensure quality, a minimum prescribed number of procedures will have to be carried out by each trainee before she/he is certified as having been trained. District training has to be flexible enough to allow this.

Action for States

The guidelines for developing in-service training plans at district level had been circulated giving all the details required at each level. The State Secretaries may issue suitable instructions to the districts to prepare the district training plans. As a first step, they may plan out training of ANMs for orientation under RCH, target free approach and dai training. The details of the orientation training are given below:

ORIENTATION TRAINING OF AUXILIARY NURSE MIDWIFES ON REPRODUCTIVE AND CHILD HEALTH, TARGET FREE APPROACH COMMUNITY BASED MIDWIFERY AND TRAINING OF DAIS.

A six days orientation training has been proposed to orient the ANMs and LHVs on reproductive and child health, target free approach, community based midwifery and training of dais. This has been felt necessary as the these basic grassroot level functionaries will play a major role to assess the service needs of various RCH components at the community level through a process of participatory assessment and plan delivery of services.

The trainees will be oriented on:

(i) RCH

- concepts and
- components

(ii) Target free approach

- need assessment/estimation
- planning service delivery
- monitoring

(iii). Community based midwifery

- essential care for all pregnant women
- identification of high risk cases
- management of complications
- infection control measures
- essential newborn care

(iv). Basic training skills in imparting TBA training

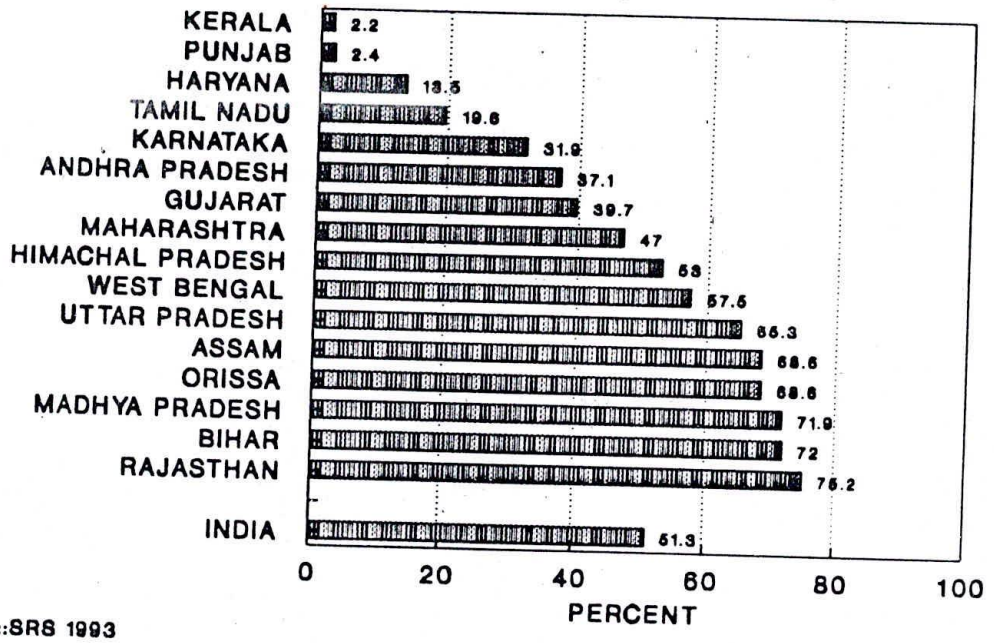
- concepts
- methodology
- use of training material
- organizing monthly sessions
- contents and scheduling

The item No.3 and 4 above has been included specially in view of large number of cases of deliveries being attended by untrained birth attendants or others. There has been no major shift in this pattern over last few decades in spite of dai training programme being in place since the Second Five Year Plan. As per SRS estimates of 1993, still more than 51% of the deliveries are being attended by untrained birth attendants. Overall 23% of deliveries were institutional with the range of less than 5% in Rajasthan and Uttar Pradesh to more than 90% in Kerala.

In eight of the 15 large States for which information is available, less than 20% of deliveries were institutional. The following figure shows that there are eight major States where the attendance at delivery by untrained birth attendants are more than the national average. In another four States percentage of deliveries attended by untrained birth attendants ranges between 31.9 to 47.

Table II

MEDICAL ATTENTION AT DELIVERY
ATTENDED BY UNTRAINED BIRTH ATTENDANTS



RGI::SRS 1993

It can also be observed that the perinatal, neonatal and infant mortality are significantly lower in the States where the deliveries by trained personnel are

higher. Attempts to train the traditional birth attendants through an intensified training programme was also started in 1994-95 in a time bound manner to train one birth attendant in each village and to complete the training of the traditional birth attendants by the end of the year 1996-97. The training so far organized were hospital based which were away from the surrounding in which the traditional birth attendants practice has resulted in not adopting the skills taught to them.

The present approach is to provide continued education/training to the traditional birth attendants at the community level and orient the traditional birth attendants on safe delivery practices through monthly interactions sessions at the sub-centres with the ANM and LHV of the area. The 12 important issues have been identified and one issue will be discussed by the ANM during this monthly meeting with the TBAs.

In order to establish the linkage between the ANMs and the Traditional Birth Attendants and to upgrade the trainer's skills of ANM a six days' training is proposed under the present scheme.

OBJECTIVE

1. To train ANMs as trainers for TBAs to impart training on safe delivery practices.

2. To orient the faculty members of SIHFW, HFWTC and ANM training schools on community based midwifery so that this knowledge could be imparted to future trainees in these institutions as well as impart training to ANMs on TBA linked community based midwifery service.

3. To orient ANMs on participatory planning in target free approach.

4. To orient the ANMs on basic training skills.

The ANM training school shall organize training of inservice ANMs and LHVs to impart training on the basic midwifery skills.

The faculty members of the ANM training centres will be trained at HFWTC/ SIHFW in a six days training.

The State MCH & Family Welfare Officers will be oriented on the above training course in a meeting proposed to be held late in 1996.

COMMUNITY AWARD SCHEME AND FAMILY WELFARE PLAN FOR WATERSHED PROJECT AREAS

In order to secure greater involvement of the community in the National Family Welfare Programme, the Department of Family Welfare introduced two new schemes in 1996, to be implemented on pilot basis for one year in the first instance.

COMMUNITY AWARD SCHEME

The objective of the scheme is to involve the community at the village level to take an active interest in the implementation of the Family Welfare Programme. This scheme is operational in the calendar year 1996.

One revenue village with a population of more than 500 in each district of the country, which registers the lowest birth rate, lowest infant and child mortality rate and lowest maternal mortality rate in that district during the year, will be given an award of Rs.2.00 lakhs. To become eligible for the award the village must record 100% civil registration of births and deaths.

All revenue villages with a population of over 500 will be eligible for the Community Award Scheme. Villages which intend to participate in the scheme in a year would have to register in the beginning of the year with the district authorities. The eligibility of the village for the award will be decided by the District Committee.

The award money will be presented to the village Pradhan/Sarpanch and will be credited to the Village Panchayat account. The award money has to be used for

developmental activities in the revenue village itself and not in any of the other village forming part of the same Panchayat. The utilisation of the award money would be for developmental purposes in the village and not for the payment of salaries of the staff of the Panchayat, maintenance of Panchayat amenities, office expenses, acquisition of vehicles etc.

The scheme aims at promoting community participation in efforts to reduce the infant, child and maternal mortality and birth rate and improve the general health profile of the people of the village through creating community awareness and better utilisation of the existing services. This scheme is applicable to all States and UTs.

So far nine States viz. Uttar Pradesh, Assam, Andhra Pradesh, Goa, Punjab, Gujarat, Kerala, Sikkim, Mizoram and two UTs viz. Daman & Diu and Andaman & Nicobar Islands have sent their district wise proposals amounting to a total of Rs.3.52 crores as of 20th November, 1996. All other States/UTs have been reminded to submit their detailed proposals.

FAMILY WELFARE PLAN FOR WATERSHED DEVELOPMENT PROJECT AREAS OF NWDPRA

The Ministry of Agriculture and Cooperation has an ongoing scheme named the "National Watershed Development Project for Rainfed Areas (NWDPRA)" for watershed development, focusing on agricultural and environmental improvement, scientific land use, increasing production of food-grains etc. through active participation of groups of beneficiaries on order to bring about convergence of developmental programmes and to attain certain social and demographic objectives in addition to the agricultural and environmental objectives.

Strategy

Rural

The out reach established under the Pulse Polio Immunization (PPI) Programme is proposed to be utilised to provide services to both women and children. For the PPI Programme 6.5 lakh PPI booths were created. Since there are approximately 1.5 lakh Sub-centres it is estimated that four PPI booths fell in the jurisdiction of every Sub-centre. It is envisaged that each of these PPI booths will function as an out reach point under the "Matri Suraksha Abhiyan" by rotation. It is proposed that the booths be activated for service on sundays by rotation so that each booth gets activated at least once a month. The service will be provided by the ANM. The schedule of operationalising the 4 booths in the jurisdiction of each sub-centre ANM will be prepared by the LHV in consultation with the concerned PHC doctor. The dates for activising each of the booths will be widely publicised in the neighbouring areas. The ANMs will be provided a day off in the week in lieu of work done on sunday.

Urban

The urban areas are comparatively well served as regards secondary and tertiary level institutions for reproductive and child health. The focus of the "Abhiyan" in urban areas will be on reaching the under served areas, specially urban slums and peri-urban localities. It is assumed that about 20 per cent of the PPI booths in urban areas were located in or near slum areas. It is proposed that these posts be utilised under the "Matri Suraksha Abhiyan". Here again it should be ensured that each post is activated at least once a month and that the community are informed well in time.

"During Nineth Plan, Family Welfare Programmes which include bringing down Infant Mortality Rate (IMR), Child Mortality Rate (CMR), Maternal Mortality Rate (MMR) and the Crude Birth Rate (CBR) to a level lower than the State or National rate, whoever is lower may also be implemented in NWDPRA watersheds in consultation with Ministry of Health and Family Welfare".

A new scheme 'Family Welfare Plan for Watershed Project Areas' has been initiated on pilot basis for the financial year 1996-97 which aims to integrate family welfare with development efforts in agriculture and soil conservation sector. Under this scheme, every village having a micro-watershed project under the 'National Watershed Project for Rainfed Areas' will prepare a village level family welfare and health care action plan. Rs.5000/- will be given to every village in the watershed for purchase of medicines required for essential MCH Care, for organising health camps, and for emergency obstetric cases. This scheme has been taken up in 19612 watersheds of 12 selected States in the financial year 1996-97 on a pilot basis. The estimated number of villages in these 19612 micro watershed projects would be about 9,000.

Under the scheme, the Mitra Krishak Mandals (MKM) would be given an amount of Rs.5,000/- for each village per year. The annual financial outlay required for the scheme would be Rs.4.5 crores (Rs.5000 x 9000 villages). Proposals amounting to Rs.4.19 crores have been received from 11 States as on 2nd December, 1996.

OBSERVANCE OF "MATRI SURAKSHA ABHIYAN" ONCE EVERY WEEK FOR IMPROVED HEALTH OF WOMEN WITH SPECIAL EMPHASIS ON REPRODUCTIVE HEALTH.

Introduction

The National Family Health Survey 1992-93 revealed that the Maternal Mortality Rate in the country is 437 deaths per 100,000 live births. The rural MMR (448) is 13% higher than the urban MMR (397). It is matter of concern that inspite of Safe Mothoerhood interventions the maternal mortality in the country is unacceptably high. In addition to avoidable risks of mortality women suffer from a very high morbidity specially reproductive health morbidity due to a variety of reasons like poor status of women, inaccessibility of services and because of the confidential nature of their problems.

To cater to the issues mentioned above it is proposed that all States and Union Territories launch "Matri Suraksha Abhiyan" under which reproductive and child health services will be provided to them very near their homes once every week.

Analysis of service data for the year 1995-96 from 350 districts is annexed. As will be noticed the ante-natal registration of cases is low as is the proportion of deliveries conducted by trained personnel. The proposed Abhiyan will also aim at achieving the National Health Policy Goal of achieving ante-natal care and deliveries by trained workers for all pregnant women.

Strategy

Rural

The out reach established under the Pulse Polio Immunization (PPI) Programme is proposed to be utilised to provide services to both women and children. For the PPI Programme 6.5 lakh PPi booths were created. Since there are approximately 1.5 lakh Sub-centres it is estimated that four PPI booths fell in the jurisdiction of every Sub-centre. It is envisaged that each of these PPI booths will function as an out reach point under the "Matri Suraksha Abhiyan" by rotation. It is proposed that the booths be activated for service on sundays by rotation so that each booth gets activated at least once a month. The service will be provided by the ANM. The schedule of operationalising the 4 booths in the jurisdiction of each sub-centre ANM will be prepared by the LHV in consultation with the concerned PHC doctor. The dates for activising each of the booths will be widely publicised in the neighbouring areas. The ANMs will be provided a day off in the week in lieu of work done on sunday.

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The urban areas are comparatively well served as regards secondary and tertiary level institutions for reproductive and child health. The focus of the "Abhiyan" in urban areas will be on reaching the under served areas, specially urban slums and peri-urban localities. It is assumed that about 20 per cent of the PPI booths in urban areas were located in or near slum areas. It is proposed that these posts be utilised under the "Matri Suraksha Abhiyan". Here again it should be ensured that each post is activated at least once a month and that the community are informed well in time.

REFERRAL

It is expected that the check-up of women by ANMs would lead to identification of cases which require interventions by doctors or specialists. It would be important to identify institutions where cases which need specialist care are to be referred. In the rural areas referral points will be the Primary Health Centres, Community Health Centres, First Referral Units, PP Centres and District Hospital.

In urban areas nearby PP centres, MCH Centres or hospitals could be identified as referral points.

Special care for referral cases : A **special day** for care of referred cases should be designated in each of the identified referral institution. On the day services of specialist doctors should invariably be provided. Adequate publicity about the venue and date for care of referred cases should be made.

SERVICES PROPOSED TO BE PROVIDED

Ante-natal Check-up and Services

- Recording of medical and obstetrical history.
- General physical examination to identify high risk features like pallor (anaemia), swelling of face and feet, etc.
- Breast examination.
- Recording of Height
  Weight
  Blood Pressure
- Abdominal examination to monitor progress of pregnancy
- Advice regarding food and rest

- Prophylaxis against anaemia
- Therapeutic doses of IFA for anaemic cases
- TT immunization
- Referral of cases of high risk cases to appropriate institution

Counselling and Services for Fertility Regulation

- Advice ante-natal cases for spacing
- Provide oral contraceptives
- Provide condoms
- Counsel women with young children for spacing with I.U.D. Inform women who wish IUD insertion when and where services will be available.
- Refer couples who have completed their families for sterilisation
- Guide women who require MTP to appropriate health institution.
- Refer couples with primary or secondary infertility to PHC MO/Gynaecologist for management.

Identification and Referral of Women with Suspected Reproductive Tract Infection

- Women who complain of vaginal discharge, constant lower abdominal pain, lesions on external genitalia should be referred to the medical officer for examination and advice.

Services for Children

- Immunization against all vaccine preventable diseases under UIP.
- Vitamin A Prophylactic doses.
- Advice/treatment/referral of cases of diarrhoea and pneumonia.

- Advice mothers about exclusive breastfeeding and appropriate weaning as applicable.
- Identify children with severe mal-nutrition for management at the PHC/FRU level.

Equipment/drugs etc. which will be required

Basic equipment and drugs needed will be taken by the ANM to the booth. She will provided with the services of a helper to carry these. The following would be required :

- Weighing machine
- BP instrument
- Haemoglobinometeres
- Fetoscope
- Oral contraceptives
- Condoms
- Vaccine carrier with vials of all UIP antigens
- Sterilised syringes and needles
- ORS packets
- Cotrimoxazole tablets
- Vitamin A solution
- Stationery for recording history and referrals

Resources

The Central Government will provide honorarium for the "helper" mentioned in para above. In addition, a massive publicity campaign to orient and inform the people about the Abhiyan will be undertaken utilising all media channels. States

and Union Territories will be expected to launch area specific campaigns in conjunction with the national publicity campaign. The drugs and supplies provided under the National Family Welfare Programme will be utilised for Services at the booths. States and Union Territories would be responsible for provision of Specialist Services for referral cases.

MATRI SURAKSAH DIVAS

In order to focus National attention on the issue of women's health and safe motherhood it is proposed that the day preceding the World Population Day i.e. the 10th of July every year be observed as Matri Suraksha Divas.

On this day a Health Mela specially focusing on reproductive and child health issues will be observed in every Community Health Centre in the country. In urban areas appropriate health institutions like municipal hospitals, P.P. Centres, urban F.W. Centres should be identified for organising the Matri Suraksha Divas. Apart from provision of services of an expert Gynaecologist for management of complicated cases, services for counselling and awareness generation for reproductive and child health issues will also be provided. To attract the people activities like fun-fair, film shows, puppet shows, street plays specifically incorporating the messages of reproductive and child health will also be organised. Wide publicity will be given by the State Govt. before the Mela.

Resources

Services of the Gynaecologist and drugs and supplies will be supplied by the State Government. Support for organising IEC activities associated with the Mela will be provided by the IEC Division of Department of Family Welfare.

The health Mela on Matri Suraksha Divas will culminate into World Population Day on the next day i.e. 11th July of each year where the various mahila groups like mahila Swasthya Sanghs, ANMs, Women group involved in income general activities will take pledge to dedicate their services for Matri Suraksha in their daily work.

Table No. 2

ANC REGISTRATION AND DELIVERIES REPORTED - ALL INDIA

11/12/96

Cumulative upto the month of March, 1996

State	Estimated Pregnancies (Proportionate)	ANC Registration		Deliveries Reported					Referral Index (Complicated Cases as % of TDR)	Month Last Reported
		Numbers	As % of Estimated Pregnancies	Total (TDR)	As % of Estimated Deliveries	Institutional Deliveries as % of TDR	By Untrained Personnel as % of TDR	By trained Personnel as % of TDR		
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
ANDHRA PRADESH	968201	874237	90.29	600164	61.99	23.59	56.65	19.76	1.74	Mar,96
ARUNACHAL PRADES	12300	4505	36.63	1977	16.07	97.47	0.76	1.77	0.10	Mar,96
ASSAM	592038	406627	68.68	129995	21.96	39.07	37.22	23.72	1.05	Mar,96
BIHAR	366965	128173	34.93	53568	14.60	15.36	64.49	20.15	0.49	Mar,96
GOA	Not Available									
GUJARAT	314450	278909	88.70	214502	68.21	35.28	57.72	7.01	4.34	Mar,96
HARYANA	279870	246100	87.93	179381	64.09	11.11	66.03	22.86	1.47	Mar,96
HIMACHAL PRADESH	92293	84481	91.54	60422	65.47	23.13	58.37	18.50	0.94	Mar,96
JAMMU & KASHMIR	38098	10683	28.04	2710	7.11	59.78	23.76	16.46	1.25	Mar,96
KARNATAKA	1187675	1037968	87.39	711532	59.91	39.16	53.06	7.79	2.22	Mar,96
KERALA	343600	253116	73.67	224113	65.22	96.64	0.79	2.57	0.90	Mar,96
MADHYA PRADESH	1554800	1351658	86.93	1046417	67.30	22.74	56.60	20.66	0.82	Mar,96
MAHARASHTRA	1607500	742430	46.19	1817467	113.05	69.92	22.27	7.80	0.58	Mar,96
MANIPUR	37630	59139	157.16	16436	43.68	67.84	26.30	5.87	1.01	Mar,96
MEGHALAYA	18350	11827	64.45	6906	37.63	35.65	29.97	34.38	1.42	Mar,96
MIZORAM	18802	13533	71.98	12872	68.46	39.56	38.74	21.70	1.17	Mar,96
NAGALAND	15774	1284	8.14	506	3.21	71.74	19.96	8.30	0.00	Mar,96
ORISSA	643907	333532	51.80	244730	38.01	20.76	57.92	21.32	0.67	Mar,96
PUNJAB	218068	170108	78.01	111985	51.35	19.95	69.32	10.73	2.46	Mar,96
RAJASTHAN	597972	320076	53.53	178186	29.80	32.51	50.84	16.65	1.08	Mar,96
SIKKIM	1870	1135	60.70	1107	59.20	39.48	57.45	3.07	0.45	Mar,96
TAMILNADU	1109340	1150570	103.72	967689	87.23	74.99	19.54	5.47	5.28	Mar,96
TRIPURA	Not Available									
UTTAR PRADESH	2967461	2519292	84.90	2256096	76.03	12.29	80.18	7.53	0.15	Mar,96
WEST BENGAL	1598200	1019634	63.80	845804	52.92	41.67	28.74	29.59	1.09	Mar,96
ANDAMAN & NICOBA	7800	3572	45.79	2606	33.41	66.58	13.32	20.11	3.68	Mar,96
CHANDIGARH	3193	5306	166.19	2514	78.74	89.78	8.19	2.03	1.59	Mar,96
DADAR & NAGAR HA	Not Available									
DAMAN & DIU	2900	693	23.90	1729	59.62	23.66	50.14	26.20	0.12	Mar,96
DELHI	253500	227447	89.72	110859	43.75	66.62	22.09	11.29	6.55	Mar,96
LAKSHADWEEP	730	729	99.86	698	94.25	48.11	46.95	4.94	4.94	Mar,96
PONDICHERRY	5500	15666	284.84	11973	217.69	91.79	4.16	4.05	0.93	Mar,96
ALL INDIA	14858784	11272430	75.86	9814982	66.05	39.87	47.55	12.58	1.42	Mar,96

PROGRAMMES CONCERNING

HEALTH SECTOR

STATUS REPORT ON FEES FOR MEDICAL COLLEGES FOLLOWING SUPREME COURT ORDER

The Supreme Court of India in its judgement dated 4.2.93 in Unnikrishnan J.P. Vs. State of Andhra Pradesh while evolving a `Scheme' regulating admissions in professional colleges in the country, directed that each and every State Government should constitute a Committee to fix the ceiling on fees chargeable by a professional college or class of professional colleges, as the case may be. The fee fixation by the State Committees was subject to final fixation of fee by the Central Government/concerned professional councils.

The Government of India through concerned councils engaged consultancy organisations to study and suggest a suitable fee structure for private medical and dental colleges. While Medical Council of India engaged M/s. A.F. Ferguson & Co., New Delhi, the Dental Council of India engaged M/s. B.S. Raut & Co., New Delhi, for the purpose.

Based on the findings of the consultancy organisations and further recommendations of the concerned professional councils and also taking into account the increase in the intake of foreign students in private medical and dental colleges, Central Government fixed the upper ceiling of fee for payment seats as follows, which was effective for three years from 1993-94:-

Medical Colleges:-

An amount of Rs.1,15,000/- per annum per student shall be payable as fees. Out of this amount of Rs.10,000/- per student in case of medical colleges having partly own hospital facilities and Rs.20,000/- per student in case of colleges which do not have their own hospital will be paid to the Government/Authority running the hospitals utilised by such medical colleges.

Dental Colleges:-

An amount of Rs.86,000/- per student shall be payable as fees. Out of this, amount of Rs.10,000/- per student per year in case of colleges which do not have their own hospital facilities will be paid back to the Govenment/authority running the hospitals utilised by such colleges.

However, before the above fee structure could be implemented the Supreme Court in its order dated 11.8.95 raised the fee for merit seats to Rs.20,000/- per annum and Rs.15,000/- per annum and reduced the seat for payment seats to Rs.75,000 to Rs.70,000/- and Rs.65,000/- for medical colleges having own hospitals, partly own hospitals and partly Governments hospitals and entirely dependent on Government hospitals respectively and Rs.50,000/- per annum for dental colleges for the year 1995-96. The Supreme Court in its subsequent order dated 9.8.96 while continuing the above fee for 1996-97 directed the Central Government/professional councils to fix a workable fee structure within three months which will be effective from 1997-98. Acting on the above judgement the concerned professional councils have recommended the following fee structure:-

Fee Structure for medical colleges

(i) Rs.1.5 lakh per professional course (18 months) per student for medical institutions/medical colleges with their own hospitals

(ii) Rs.1.3 lakh per professional course (18 months) per student for medical institutions/medical colleges utilising the facilities of Government as well as their own hsopitals.

(iii) Rs.1.1 lakh per professional course (18 months) per student for medical institutions/medical colleges utilising the facilties completely provided by the Government hospitals.

(iv) Rs.15,000 for each professional course per student for free seats.

(v) $75,000 to be charged from NRI/foreign students for the complete MBBS course.

Fee structure for dental colleges

(i) Rs.1.4 lakh per year for independent dental college
(ii) Rs.1.0 lakh per year attached to medical college
(iii) Rs.15,000 for free seats.
(iv) $30,000 as one time payment.

The recommendations of the professional councils are under consideration in consultation with the State Governments.

COMPULSORY RURAL SERVICE/FILLING UP OF VACANCIES IN RURAL AREAS

In India, as per 1991 census, out of population of 846 million persons 29.48 per cent live in urban areas and 70.52 per cent living in rural areas have inadequate health and medical care facilities. The large rural population is scattered in 5.57 lakh villages. A good deal of imbalance exists between rural and urban areas in the provision of medical care services.

Obligatory Service for 2-3 years for doctors in rural areas

At present it is not compulsory for doctors to serve in rural areas for 2-3 years immediately after joining State/Central Government service. The Central Council of Health and Family Welfare in its meeting held on 11th October, 1995 passed the following resolutions to meet the shortage of allopathic doctors in rural areas:-

(i) "In order to meet the shortage of allopathic doctors in the rural areas, suitable amendments be brought into the M.C.I. regulation that a permanent registration will be given to M.B.B.S. doctors only after they have served at least for three years in rural areas notified by the State Governments.

(ii) The Council notes with great concern the above scarcity of doctors in rural areas and recommends that rural posting for a specific period be made compulsory and also a pre-requisite before admission to post-graduate courses".

The following recommendations were made at the Conference of Chief Ministers on Basic Minimum Services held on 4th and 5th July, 1996:-

"In order to overcome the shortage of qualified doctors to man the Primary Health Care System, 2-3 years service in the rural areas should be made obligatory for medical graduates/post-graduate before they are given permanent registration".

The Medical Council of India has commented that there is no real shortage of doctors of modern scientific system of medicine(allopathy) in the country, but only mal-distribution. The State Governments may ensure rural posting before appointing doctors to Government posts. Incentives should be given for doctors in rural areas such as reservation in post-graduate courses. Further, extending the period of pre-registration to another three years is not practical/feasible and will not serve any purpose. If permanent registration is withheld, unregistered doctors will be posted in rural areas while duly qualified doctors will be available for urban areas. This disparity cannot be allowed. The MCI is of the view that the existing 6 months internship may be strengthened. The MCI has questioned whether the State Government would be able to provide jobs to all medical graduates passing out of the medical college in the State after the long-drawn out process (a medical graduate will have to put in five and a half years course plus a 3 year rural posting plus 3 years post-graduate course before completing his studies.).

Availability of Medical Manpower in PHCs, CHCs and Sub-Centres

At present the vacancies of Medical Officers and Specialists in the health centres in the rural areas are very large. The State Governments are required to place Gynaecologists, Paediatricians and women para-medical staff in vacant posts. The vacancy position of doctors in PHCs and specialists in CHCs is as under:-

(i) Doctors in PHCs:

Sanctioned	In position	Vacant
31,700	26,583	5,117

*(Source: Rural Health Statictics, December, 1995)

(ii) Medical Specialists:-

Name of specialist	No. of posts	No. in position	No. vacant
i) Surgeons	1353	710	643
ii) Obst. and Gynae.	1139	548	591
iii) Physicians	1104	574	490
iv)Paediatricians	845	498	347

*(Source: Rural Health Statictics, December, 1995)

Tamil Nadu Medical Service-compulsory rural service of doctors and decentralised recruitment of doctors

As per the instructions issued by the Government of Tamil Nadu on 12.1.1987:-

(i) The medical graduates immediately after their recruitment as Asstt. Surgeons in Tamil Nadu Medical Service are posted in non-teaching medical institutions outside Madras City;

(ii) The Medical Officers, without any discrimination, on first appointment are posted in PHCs to serve there for a minimum period of 3 years;

(iii) In case of holders of post-graduate medical qualifications the period of service in rural areas is one to two years;

(iv) In case of Super-Specialists and holders of non-clinical post-graduates rural service is not insisted upon. Also relaxation is given to post-graduate students and they are posted in District Hospitals.

Recruitment of Asstt. Surgeons to Tamil Nadu Medical Service-Selection by Tamil Nadu Public Service Commission

The Government of Tamil Nadu found shortfalls in the procedure of filling up of vacant posts of Asstt. Surgeons in Tamil Nadu Medical Service. Candidates selected for the post did not join duty or showed tendency of indifference to duty or adopted various methods for transfer to places near Madras or of their choice. To provide uninterrupted medicare and health service to the rural public the following decisions were taken by the Government of Tamil Nadu:-

(i) The State was divided into nine Zones and the Tamil Nadu Public Service Commission called for application zone-wise.
(ii) Those selected were stipulated to serve in the zone for 10 years.
(iii) Zone-wise selection of 300 candidates are to be done every year.
(iv) The selected candidates are to be given 30 days to join duty.
(v) Though Medical Officers are selected zone-wise, their seniority would be common in the merit list of TPSC.

Condition imposed by Government of Karnataka for Doctors to serve in Rural Areas for Five Years

For filling up vacancies in rural hospitals, Government of Karnataka appoints doctors on contract basis in rural areas and no transfer is allowed. While recruiting doctors through Karnataka Public Service Commissioin, a conditiion is imposed that doctor concerned would work in rural areas for five years.

The condition for contract appointment of doctor in rural areas in Karnataka are as under:-

(1) The contract appointment is for a maximum period of three years.

(2) As this appointment is made to a particular dispensary in rural areas, there is no scope for transfer to any other hospital or on deputation.

(3) The pay is fixed at Rs. 4000/- per month subject to discharge of duty satisfactorily.

(4) The contract doctors are eligible to medical, leave facilities available to officials of equal rank.

(5) The contract doctors are not eligible for regularisation, pension, gratuity, pay scale or any other allowances.

(6) Such doctors give an undertaking to District Health Officers after reporting for duty, etc.

The System of Ad-hoc Recruitment of Doctors in Rajasthan for Rural Areas

The Government of Rajasthan for ensuring availability of doctors in rural areas is adopting to a Centralised ad-hoc recruitment for peripheral rural health centres. The State Government has reserved 50 % of the seats in post-graduate courses for in-service doctors. The eligibility condition for joining post-graduate courses in Rajasthan is 5 years service including three years in rural areas. An exception has been made in the case of doctors working in desert and tribal areas where two years service is counted for the purpose of admission to post-graduate courses.

ISSUES FOR CONSIDERATION BY THE STATE GOVERNMENTS/U.TS.

The Ministry of Health & Family Welfare took initiative to call Health Secretaries of selected States, namely, Tamil Nadu, Rajasthan, West Bengal, Karnataka and Secretary, MCI to elicit their views as to how they were approaching the problem.

It is suggested that all other State Governments may consider introducing the regional decentralised recruitment policy for doctors as is being done in Tamil Nadu by filling up vacancies of doctors in rural areas and reserving a certain percentage of post-graduate seats for inservice medical officers who have put in 2 to 3 years service in rural areas.

At present every candidate is required to undergo after passing the final M.B.B.S. examination compulsory rotational internship to the satisfaction of the University for a period of 12 months so as to be eligible for the award of M.B.B.S. degree and full registration to practice medicine. The internship training includes training in medicine, surgery and Obst. and Gynae. and in community health work in Rural Health Training Centres of upgraded PHCs. The posting in rural health Centre is for a period of six months. The D.G.H.S. is of the view that the entire period of one year should be spent in rural areas. This issue is required to be decided in consultation with State Governments.

About 3000 post-graduate doctors are passing out of medical colleges in the country every year. The Ministry of Health & FW is of the view that a percentage of post-gradute seats may be reserved by State Governments for in-service medical officers as is being done in Rajasthan. The eligibility conditions for joining post-graduate course for in-service doctors may be made 5 years service including 2-3 years service in rural areas.

EPIDEMIOLOGICAL SURVEILLANCE AND SUPPORT SYSTEM

Disease causing microbes have threatened human health for centuries. Though the present health machinery responds better as compared to the situation decades earlier, yet the recent plague (1994) and dengue fever (1996) outbreaks have demonstrated clearly that the executive health agencies need to be better prepared to perceive, recognize and respond rapidly to public health threats arising out of disease outbreaks. The key to recognize new or emerging infectious diseases and to tackle the resultant problems is surveillance.

Epidemiological surveillance is a prerequisite to modern, effective control and prevention of communicable diseases. It means understanding a disease as a dynamic process involving the ecology of the infectious agent, the host reservoir, the vectors and the environment as well as the complex mechanism involved in the causation of the disease and its spread. It also implies follow up of specific diseases in terms of morbidity and mortality in time and place and keeping track of the circulation of etiological agents in man and the environment including animal population. This also includes all kinds of laboratory investigations, such as isolation, identification and typing of etiological agents, investigation of the biological properties of the agents and different serological studies of individual and population groups.

Attention also needs to be paid to other factors which may influence the spread of infection and the incidence of disease, such as social and economic changes in the country, population movements, large industrial and agricultural investments like building of dams, irrigation etc. or international trade, export and import of live animals, meat and meat products and poultry.

National Institute of Communicable Diseases (NICD) was established in 1964 to provide technical expertise in the field of disease control activities and act as a centre of excellence for building up man-power, providing technical guidelines and advice to various health implementing agencies including national authorities, undertaking surveillance for major communicable diseases and maintaining watch over emerging newer health problems and recommending appropriate measures to the Government to tackle the situation.

The number of outbreak of communicable diseases has been increasing in recent years. There could be several reasons for this. Increased rapidity of national and international travel and the greater distances travelled, extensive deforestation and irrigation works, neglect of insect and vector control programmes, explosive urbanisation and over crowding associated with gatherings, frequent movement of population of refugees, large scale industrial food processing etc. contribute to the same.

Disease surveillance activities shall cover mortality and morbidity reporting, individual case investigation, epidemic case investigation, complete laboratory investigation leading to detailed characterisation of the etiological agents involving molecular epidemiological parameters, epidemic field investigation, epidemiological survey including immunological studies, animal reservoir and vector distribution of diseases with natural foci, biological products and drug utilisation, demographic and environmental data, guidelines for the implementation agencies, feed back and dissemination of information, identification of vulnerable areas, ensuring community participation in surveillance, appropriate health education education and IEC activities and collaboration with appropriate institutes inside and outside the country.

Diseases proposed to be covered for Surveillance

Organised surveillance machinery exists for malaria, leprosy and TB. The surveillance machinery for JE, Kala-azar, cholera, rabies, leptospirosis,

plague, viral hepatitis, salmonellosis, dengue, typhus, viral encephalitis, meningococcal meningitis, measles, polio though exist but are often inadequate to meet the needs of emergency response in the event of an outbreak.

There is an urgent need to establish an appropriate epidemiological surveillance programme covering all important epidemic prone diseases so that very early response could be instituted to prevent large scale morbidity and mortality. The diseases which are proposed to be covered under the proposed action plan are: cholera, plague, salmonellosis, shigellosis, rickettssosisa, JE, kala-azar, dengue, leptospirosis, rabies, AIDS, poliomyelitis, measles, tetanus, viral hepatitis, meningococcal meningitis, diphtheria, whooping cough, influenza, rubella, TORCH group of infections etc.

Expected outcome of Disease Surveillance Programme

A well designed and well implemented surveillance programme can:

- detect unusual clustering of cases of a disease in time and space in geographic area
- initiation of early and adequate response
- document the geographic and demographic spread of an outbreak
- estimate the magnitude of problem
- help in describing natural history of disease
- identify factors responsible for emergence of disease
- facilitate laboratory and epidemiological research

- assess the success of intervention efforts

-creation of public awareness through health education and IEC.

Issues

There have been a large number of drawbacks with the existing mechanism of surveillance of communicable diseases. Some of the major issues are:

1. Absence of a well defined, actively co-ordinated and effective network of surveillance machinery.

2. Non availability of appropriate guidelines for surveillance

3. Inadequate laboratory support

4. Lack of institutional support and appropriate linkages

5. Poor primary health care infrastructure in urban areas

6. Non-involvement of NG0s and private practitioners

7. Inadequate health education to the community

8. Absence of effective legislation and poor implementation of existing legislation

9. Weak co-ordination between various agencies/institutions

10. Resource constraints

The 4th Conference of Central Council of Health & Family Welfare had recommended the launching of a National Disease Surveillance Programme

alongwith appropriate laboratory support services including entomological services and the networking of disease reporting through a computerised HMIS covering all States/UTs.

The Government of India has established National Apical Advisory Committee and Response System under the Chairmanship of Union Secretary (Health). A Sub-Group has also been constituted under the Chairmanship of Prof. V. Ramalingaswami to work the detailed modalities of the disease surveillance programme.

Broad components of the disease surveillance programme as a centrally sponsored scheme

1. National Institute of Communicable Diseases (NICD) to be redesignated as National Institute of Control of Diseases (NICD) in the pattern of CDC, Atlanta and will be the nodal agency to plan, monitor, review programme implementation and guide health care agencies in implementing the operation of disease surveillance programme.

2. Existing laboratories should appropriately be networked through electronic means like FAX, E-mail, NICNET etc., for harnessing the information already available & generating appropriate information to strengthen capability of detection of early warning signal.

3. Strengthening of National/State/District epidemiological capability in perceiving threats, detecting threat and responding appropriately.

4. Uniform notification system in the country for diseases with epidemic potentiality and instituting National health regulations to

minimise spread of the disease from one area to another.

5. Computerised HMIS to be available all over the country.

It is urged that the Central Council of Health & Family Welfare takes cognisance of existing inadequate disease surveillance system and its resultant adverse impact on the economy of the country and resolves to launch National Disease Surveillance Programme as proposed above during the Ninth Five Year Plan.

Agenda Item No. XV

NATIONAL MALARIA ERADICATION PROGRAMME

Strengthening of MIS System for proper monitoring.

Malaria has been contained around 2 million cases in the country since 1984. However, from 1994 onwards it is being observed the Malarial focal outbreak are being reported from some areas of the country which necessitates timely alert of the States for undertaking appropriate preventive measures. All the more such problems are emerging from the areas of low endemicity for malaria wherein high casualties also occur because of unpreparedness of the States facing such situation which may be explained by the outbreak in Rajasthan in 1994. It is important to notice that any fluctuation from earlier trends at the early stages for averting such exigencies is only possible by developing proper information/reporting system at the district level with a malaria epidemiologist and entomologist. It has been observed that the reports from the States take on an average two months to reach the Directorate of NMEP. Even with the best of efforts the same may not be useful to face an outbreak/epidemic situation since malaria is a local and focal disease. Therefore, an Epidemiological Cell should be established at the District level manned by trained epidemiologists and entomologists for continuous monitoring and to report any abnormal situation pertaining to all vector borne diseases including malaria.

In order to strengthen the MIS system for proper monitoring of the malaria situation to serve the purpose of early detection, the provision of appropriate software programme at the district level is a must. With the help of these programmes, the epidemiologists at the district level will be able to update the malaria situation quickly and analyses the same in the most scientific manner.

and inform the District and State Programme officers to take appropriate and timely control measures which are at present not possible with the time gap of 2 months on an average spent over the consolidation of information.

The present infrastructure available with the NIC at the district level including the NICNET facility should be made use of by the State/District Malaria Officers so that at all the State headquarters consolidation is done. It should be the responsibility of the State Headquarters to further communicate this to the Directorate of NMEP and to share the information with the State Health Authorities for under taking appropriate measures to control the situation.

CALENDER OF EVENTS AND ACTIVITIES FOR ALL VECTOR BORNE DISEASES

Based on the information system proposed to be strengthened, a calender of events and activities for each of the vector borne diseases would be circulated wall in advance to all the State Governments for undertaking preventive measures.

This would inter-alia include specific locations requiring attention both from the point of view of prevention, spraying schedule, and transmission period.

The State shall be advised to strictly adhere to the action points contained in the calender of events and activities proposed to be circulated to them by the Directorate of NMEP.

CONTINGENCY PLAN FOR VECTOR BORNE DISEASES INCLUDING DENGUE.

As a long term measure, a contingency plan giving specific details relating to States' preparedness to contain any outbreak or epidemic situation of vector borne diseases is under formulation by the Directorate of NMEP.

This contingency plan shall be specific to vector borne diseases and for all the States highlighting the action points and calender of activities required at each level of the Health functionaries in the States. Since the contingency plan is still under formulation, the State Governments are requested to offer any suggestions in this regard.

Strengthening of zonal and State level Entomological component for area specific vector control measures and forecasting.

The entomological component is very important as far as vector control operations are concerned. This component is lacking. Presently, there are 72 zones in the States. Only 54 posts are filled up at the zonal level. There is, therefore, an urgent need to fill up all the vacant posts.

The main function of the entomological team is to identify the present transmission of vector borne diseases, particularly malaria and develop integrated control strategy to prevent morbidity and mortality in addition to forecasting the diseases situation. So far appreciable information has been contributed by theses zones for entomological assessment for stratification of areas requiring insecticide application and also for suggesting appropriate control measures to reduce malaria and incidence of Japanese Encephalitis to a tolerable level. These entomological teams do monitor susceptibility status of vectors and other entomological indices. Depending on their findings, the present control strategies have been finalised. Therefore, strengthening of these component needs top priority under there present circumstances.

Strengthening of Basic Health Services by States.

With the introduction of Multi Purpose Workers Scheme, effective implementation of National Health Programmes including NMEP is directly related to the efficient functioning of the basic health services. These include

surveillance and treatment of malaria cases, laboratory services and spraying of insecticides. Keeping a sizeable number of Multi Purpose Workers (MPW) and laboratory technicians posts vacant for a long period, as is observed in most of the States, adversely affects basic malaria work at the field level.. It therefore, becomes imperative that the State Governments take immediate action to fill up all the posts relating to malaria works and other posts coming under the purview of basic health services without any further loss of time.

Development of skilled Manpower for Drug Sensitivity Tests at the state level.

The drug resistance is also emerging as a major problem in tackling malaria and incidence of P.faliciparum cases are increasing year by year. During the lasts few years, foci outbreaks have been reported from various parts of the country with an alarmingly high incidence of Pf. At present there are 258 (118 RIII, 71 RII) resistant foci in this country. although 13 P.falciparum monitoring teams are working under the Regional Offices of Health & Family Welfare in various States, it is difficult to cover the entire country. In such circumstances these teams may impart training to the State officials for wide coverage. Therefore, all the States should constitute Drug Monitoring Teams as per the Pf situation, of their respective States.

EARLY ADOPTION OF MUNICIPAL BYE-LAWS BY THE STATES

Considering the fact that more and more people are migrating to urban areas especially metropolitan cities the urban Malaria situation in the country is also causing concern besides emergence of new vector borne diseases like Dengue. Tools for control of vector borne diseases in urban situation have a number of limitations. It therefore, becomes imperative to prevent creation of Malariogenic conditions in urban areas.

States were advised to frame and adopt suitable Municipal bye-laws on the lines of Bombay Municipal Corporation Act. Comprehensive legal provisions exist in Bombay Municipal Corporation Act for slimination and avoidance of mosquito breeding and for removal of cause that lead to mosquito breeding within any premises.

This matter was also discussed at State Health Ministers Conference held during February 1996, wherein the States were further advised to take early action for framing and adopting suitable municipal bye-laws. No feed back has been received from the State on this important Public Health matter. State Governments may be impressed upon the urgent need to take action for adopting suitable Municipal bye-laws on the lines of Bombay Municipal Corporation Act.

THE ROLE OF STATE GOVERNMENTS IN THE IMPLEMENTATION OF NATIONAL MALARIA ERADICATION PROGRAMME

It has been observed that many states have not been able to effectively implement the Malaria Eradication Programme as per the guidelines contained in Malaria Action Programme. Reportedly, the States due to their own financial problems have not been in a position to fully contribute their mite to tackle the Malaria situation and as a result local outbreaks have been occurring

The materials supplied by the Directorate of NMEP for undertaking Vector Control measures which are crucial have not been utilised or lifted by certain States leading to loss of human lives. This must be avoided at all costs.

In the name of matching contribution, some States have reportedly shown expenditure on payment of salaries/wages. As per the guidelines of Planning Commission, under the Centrally Sponsored Scheme (Cat-II), 50% share of the State has to be on Plan side, whereas, the payment of salaries and wages is Non-Plan item.

No exception can be made to the norms of Centrally Sponsored Schemes, without the approval of full Planning Commission.

State Governments, should specifically earmark funds towards operational costs and other incidentals, so that this becomes a truly Centrally Sponsored Programme implemented effectively.

NATIONAL AIDS CONTROL PROGRAMME.

Review of Programme Implementation

Slow utilisation of funds:

Government-led efforts for control and prevention of HIV/AIDS in India began in 1985 with the launching of a pilot project for screening high risk population. In 1991 a Strategic Plan for prevention and control of HIV/AIDS was developed in consultation with World Health Organisation and World Bank agreed to provide a Credit of US$ 84 million for the implementation of this programme. The National AIDS Control Programme has been implemented during the 8th Five Year Plan as a Centrally Sponsored Scheme with 100 per cent financial assistance from the Central Government.

The programme is based on the following strategies identified for prevention and control of HIV/AIDS in the country:

(a) Strengthening Programme Management capabilities;
(b) Surveillance and Research'
(c) Information, Education and Communication (IEC);
(d) Control of Sexually Transmitted Diseases (STDs);
(e) Condom Programming;
(f) Blood Safety; and
(g) Reduction of impact on HIV/AIDS.

From 1992-93 onwards very few State Governments have utilised the full funds placed at their disposal for this Programme. In fact, as and when the programme has been reviewed with the World Bank or with State AIDS

Programme Officers, the main obstacle has been the slow utilisation of funds; the slow release of funds from the State Finance Departments to the State AIDS Programme Officers and the slow preparation of documents for enabling National AIDS Control Organisation (NACO) to seek reimbursement from the World Bank as per Agreement between Govt. of India and the World Bank.

The following steps have been taken by NACO to enable the State Governments to make optimum utilisation of available resources:-

(i) Union Minister of Health and Family Welfare has written to the Chief Ministers of all the States for expediting the implementation of the programme;

(ii) Additional Secretary and Project Director, NACO, has written to Chief Secretaries as well as Health Secretaries of all the States for speedier utilisation of funds;

(iii) Periodical meetings are held with State AIDS Programme Officers where all the components of the programme including utilisation of funds are reviewed in detail. The last meeting was held on November 20-21, 1996;

(iv) The Programme Officers from NACO are constantly visiting the States to ensure that the resources made available by the Govt. of India are fully utilised.

Inspite of these efforts, the budgeted funds have not been used as visualised in the scheme. The World Bank Credit is scheduled to come to a close on 30th September 1997. It is essential that the Council considers afresh steps to be taken by the State Governments for ensuring full utilisation of the available credit.

Involvement of Non-Governmental Organisations (NGOs) in the implementation of the National AIDS Control Programme

The National AIDS Control Programme visualises a very important role for NGOs in the implementation of the scheme. In fact, the promotion of public awareness and social mobilisation depends to a very large extent on the activities of the NGOs to mobilise . Activities in HIV-related field which NGOs could take up would include the following:-

(i) Creation of awareness and preventive education;

(ii) Service delivery through counselling, condom promotion and STD curative services;

(iii) Enabling factors (skills);

(iv) Care and support;

(v) Advocacy; and

(vi) Training.

The Programme visualises that the NGOs would be selected in urban areas for working amongst high risk behaviour groups and that the services of a very large number of NGOs would be utilised in various States. However, the experience of the last four years is that the role of NGOs in HIV control is currently marginal and requires motivation and stimulation by the States. In fact, very few of the State Governments have appointed an NGO Adviser or a nodal agency for identifying NGOs in their respective States which could be provided funds for creating awareness in the society. It is necessary that the State Governments activate themselves in this respect as the disease is fast spreading and needs to be tackled by mobilising community through NGOs.

Blood Safety

(a) Setting up of National/State Blood Transfusion Councils:

In their judgement dated January 4, 1996 in the Writ Petition filed by Common Cause concerning revamping of Blood Banking system in the country, the Supreme Court, inter alia, directed the Union Government to establish a

National Council of Blood Transfusion as a Society registered under the Societies Registration Act. It has been envisaged in the judgement that the Council would be a representative body having in it representatives from Directorate General of Health Services of the Govt. of India; the Drugs Controller General (India); Ministry of Finance in the Govt. of India; Indian Red Cross Society; private blood banks; major medical and health institutions in the country and NGOs active in the field of securing voluntary blood donations. It has also been laid down that the Additional Secretary in the Ministry of Health who is incharge of the operations of the National AIDS Control Programme would be the President of the National Council. As envisaged in the judgement that each State/Union Territory would set up a State/UT Blood Transfusion Council in their respective State/UT on similar lines. The programme and activities of the National and the State Councils are to cover the entire range of services related to operation and requirements of blood banks including the launching of all effective motivation campaigns through utilisation of all media for stimulating voluntary blood donations, launching programmes for blood donation in educational institutions, among the labour, industry and trade, establishments and organisations of various services including civic bodies, training of personnel in relation to all operations of blood collection, storage and utilisation, separation of blood groups, proper labelling, proper storage and transport; quality control and its achieving system, cross-matching of blood between donor and recipients; separation and storage of components of blood and all basic essentials of the operations of blood banking.

The National Blood Transfusion Council was set up and registered as a Society under the Societies Registration Act, 1860 on May 23, 1996. State Blood Transfusion Councils have also been set up in the respective States and UTs. The objective of including this agenda item is to sensitise the State/UT Governments to undertake activities for revamping the blood banking programme within their respective States/UTs. It may, however, be mentioned here that the Hon'ble Supreme Court has to be kept informed on the progress

being made on various directives of the judgement from time to time through filing of affidavits by Director General of Health Services. The States may, therefore, keep the Director General of Health Services informed about the progress made by them in this direction at regular intervals.

(b) Voluntary Blood Donation Programme

In 1989 the Govt. of India, Ministry of Health and Family Welfare, engaged the services of M/s Ferguson & Co. to study the status of blood banking programme in the country. One of the major shortcomings in the blood banking system pointed out in their report relates to the source of blood. According to this report, out of total quantity of 19.5 lakh units of blood being generated per annum in the country, approximately 29 per cent was contributed by professional donors. Over the years the demand for blood has increased due to spurt of private hospitals and superspeciality nursing homes all over the country. As the availability of blood has not shown parallel improvement, there has been mushrooming of commercial blood banks. According to the Supreme Court judgement, the Union Govt. and the Governments of the States and UTs are required to discourage the prevalent system of professional donors so that this system is completely eliminated within a period of two years. States/UTs are accordingly to draw up and implement time-bound programmes to generate adequate quantities of blood from voluntary donors from all sections of the society and to take steps to eliminate the system of professional donors.

(c) Post-graduate Courses in Blood Transfusion

The blood transfusion services infrastructure in the country lacks many critical resources, including acute shortage of adequately trained personnel. It is also commonly agreed that the development of facilities for higher education in Immunohaematology and Blood Transfusion in the country has not been satisfactory. Taking note of this, the Supreme Court in their judgement dated

January 4, 1996 referred to above, has directed that steps should be taken for starting postgraduate courses in blood collection, processing, storage and transfusion and allied fields in various medical colleges and institutions in the country.

The Govt. of India have initiated a number of steps in this direction. Curriculum for M.D. courses in Transfusion Medicine was got prepared and forwarded to the Medical Council of India (MCI) for approval and to initiate the process for inclusion of Blood Transfusion Medicine as a speciality for postgraduate degree courses. The MCI approved the curriculum and the Postgraduate Committee of the MCI also decided to include M.D. (Immunohaematology and Blood Transfusion) as an approved postgraduate MD Degree in Blood Transfusion. The above mentioned developments were also brought to the notice of the State Governments with the request to initiate action for starting the courses. It is urged upon the State Governments to take urgent steps in this direction.

(d) Income Tax Exemption to Donors in respect of donations made to the National/State Blood Transfusion Councils.

While directing the State Governments to set up State Blood Transfusion Councils, the Supreme Court had envisaged that the Councils are also empowered to collect funds in the shape of contributions from the trade, industry and individuals. In order to facilitate the collection of funds by the Councils, the Govt. of India have amended Section 80-G of the Income Tax Act, 1961 providing for 100 per cent deduction from gross income of the donors in respect of the donations made to the Councils.

NATIONAL TUBERCULOSIS CONTROL PROGRAMME

Tuberculosis continues to be a major Public Health problem in India. The disease affects primarily people in their most productive years of life and is commonly associated with poverty, overcrowding and malnutrition. Lack of education, environmental pollution and poor sanitation compound the problem.The condition of relative deprivation among economically weaker sections of the society and the high tuberculosis case rates in them seem to form a vicious cycle, one aggravating the other.

In India 14 million people are estimated to be suffering from active tuberculosis of which 2-2.5 million are highly infectious sputum positive cases. About 0.5 million die of the disease every year. Around 1.5 million TB cases are detected every year of which about 20-25% are positive for sputum and rest of are radiologically active sputum negative patients. It is estimated that almost an equal number of TB cases are detected and treated by Non-Government Organisations including Private Practitioners.

To combat this problem, the scheme of National Tuberculosis Control Programme (NTCP) was launched in 1962 on a 50:50 sharing basis with the States wherein the district was made the operational unit. The programme is integrated with the Primary Health Care and provides services free for all patients. So far Central assistance has been in kind (anti-TB drugs, equipments and X-ray films etc.).

At present District Tuberculosis Centres (DTC) have been established in 446 districts out of 496 districts in the country. In addition to the DTCs there are about 330 TB clinics which are mostly located in big towns and cities. Short

Course Chemotherapy (SCC) with potent anti-TB drugs was introduced in the Programme since 1982. At present 292 districts have been covered with Short Course Chemotherapy.

The objectives of the programme was to reduce suffering, disability and death from TB. However, over the last 30 years achievement under the National TB Control Programme are far short of the expectations. While reasons for such shortfall are generally known and specifically identified by two Expert Committees in 1975 and 1985, not much was done as a follow up to rectify them. While other National Health Programme like NMEP, UIP, NLEP affected substantial organisational and strategy changes and improved their overall efficacy, National TB Control Programme did not make much headway largely for want of an appropriate strategy for reaching the peripheral areas and due to gross under -funding.

The programme was last reviewed (1992) by a joint team from WHO and Govt. of India. Some of the important observations are:-

(a) Gross under-funding of the programme resulting in inadequate availability of drugs for treatment of cases.

(b) Over-reliance on radiological diagnosis as against smear testing through microscopy. Concentration of cases diagnosed at the District TB Centres and non-utilisation of the facilities available in the peripheral health institutions.

(c) Infrequent supervision, partly due to lack of mobility and partly due to inadequate number of supervisors.

(d) Poor case holding because of poor accessibility, time and cost factors involved in visiting health institutions, non-availability of

drugs, neglect of treatment following disappearance of symptoms and lack of awareness.

(e) Inadequate facility and poor quality of sputum microscopy

(f) Emphasis on case detection rather than cure

(g) Multiplicity of treatment regimen and non-adherence to the Regimen recommended under the National Control Programme.

In above context the country has adopted a revised strategy of Directly Observed Treatment (DOTS) with SCC drugs in convenient patientwise boxes being made available within easy walking distance with the objectives to achieve 85% cure rate necessary for sufficient impact on disease transmission. The strategy has been pilot tested in 6 rural districts and 10 metropolitan cities with encouraging results. The Government of India has sought World Bank assistance for the following interventions.

NEW EMERGING AND RE-EMERGING ISSUES IN RELATION TO TB CONTROL

ISSUES

Increasing disease Burden

Estimated TB incidence in 1992 - 2005 are as under and activities of National Programme remains at 1990 level.

1990 - 2064.000
1995 - 2350.000
2000 - 2678.000
2005 - 3045.000

HIV-TB co-infection

The extent of dual HIV-TB infection in the country is at present unclear but it seems reasonable to assume that there is a sizeable pool of dual infection and this would increase without intervention. It is estimated that the incidence of Tuberculosis will increase in the country during 1990 to 2005 by 0.4 additional cases/lakh population per year. Due to increasing prevalence of the HIV infection, dual infection is likely to increase resulting in increased morbidity and mortality from tuberculosis. With dual HIV co-infection need for hospitalised treatment will increase with the attendant cost liability.

Multi drug resistant TB (MDR-TB)

There is General impression that the pool of multi-drug resistant TB cases are increasing. This is largely due to irregular and incomplete treatment. No authentic survey report however,is available. Since treatment completion rate under National Programme has been below 40, there is high potential for increase in drug resistance. Management of a multi drug resistant TB patients is very expensive costing around Rs.50,000 to over 1000,000. MDR-TB patient often needs sophisticated investigation and hospitalisation. Result of treatment is also not very encouraging. The contacts are also at risk of getting MDR-TB. Prevention of MDR-TB to a large extent will be possible only if it is ensured that all the new patients put on treatment take drugs without interruption for full prescribed period.

Other important issues requiring immediate attention:-

(a) ensuring timely procurement of adequate quantity of anti-TB drugs and supply to the districts

(b) strengthening monitoring supervision at all level

(c) provide training and retraining at District level and development of training capabilities at State level

(d) community participation and NGO involvement

(e) IEC

(f) filling-up of vacancies of Laboratory Technicians in the Peripheral Health Institutions and Multi Purpose Workers.

Issue for Considration

Increasing disease burden and emergence of multi drug resistance TB unless effectively controlled now will lead to a situation in which the country will be forced to bear considerably higher expenditure in addition to substantial economic loss due to disease and disability. This situation can only be avoided by giving priority to the programme and providing requisite funds. Both the Central Government and State Governments need to increase their budget allocations to cover the critical activities, viz. Procurement and supply of anti TB drugs and other essential equipments and supplies.

Continuation of present policy of procurement of drugs on 50:50 sharing basis has failed to ensure regular supply of drugs on a rational basis.

Following options may be considered:-

(a) 100% procurement by Central Govt. However, in case of a systems failure all the States will go without drugs. The programme in such a situation may suffer as it is going to be a all or none phenomenon.

(b) Decentralisation of drug purchase by State Government. The State Health Authorities may be under pressure to spend the money for other non plan activities.

(c) The State Govt. may undertake procurement process and place supply order. The payments may be made directly by P.A.O., DGHS.

For this activity State Govt. may determine their procurement agency, call tender by National Competitive Bidding procedures as per specifications given by the Central Govt. After a decision is made on the bids, the State Govt. may place supply order within the financial allocation communicated by the Central Govt. The State Govt. may carry out quality testing as per laid down procedure. The suppliers may submit their bills with certificates of receipt by the State Store directly to the P.A.O., D.G.H.S. for payment.

However, in view of the pre-condition by the World Bank that all drugs should be procured by International Competitive Bidding for their re-imbursement, it may not be possible to decentralise the procurement of drugs to the State level as the World Bank support for anti-TB drugs will extend for all sputum positive cases in the country.

Regular supervision of D.T.C. key staff by the State level programme officers and frequent supervision of field staff (Lab. Tech., MPWs) by District officers (CMO, DTO) and by paramedical supervisors is critical for maintaining quality of services at optimal level. Present state of poor programme performance is largely due to inadequate supervision. One of the major reasons for this lapse is lack of mobility which is the outcome of poor transport facility, POL and maintenance fund.

A vehicle should be available to DTO and his key staff for which following steps are necessary:

(a) Supply of vehicle from Central Govt. to all DTCs not having a separate vehicle for D.T.C. work.

(b) State Govt. may enhance the provision for POL & maintenance to ensure visit of each PHI atleast once every quarter as per NTP norms for supervision.

District TB Societies may be established in each district to monitor and evaluate the Programme at District level and ensuring accountability and coordination with NGOs.

State Governments may provide adequate fund for training and IEC at District level.

Levy nominal charges on initial registration and issue of identity cards to patients so as to imbibe a sense of participation and involvement in them.

Establish State TB Training and Demonstration Centrel in all States.

Agenda Item No.XVIII

NATIOANAL LEPROSY ERADICATION PROGRAMME

Intensified IEC Activities :

There is urgent need to flush out all hidden cases of leprosy through intensive public awareness campaign so that patients report voluntarily. This should require involvement of both leprosy and GHC staff including the staff of ISM system and intensive use of media. State Governments. should issue a circular to all district CMOs for giving further instructions for full cooperation of GHC staff in districts and by the staff of ISM system for distributing leprosy drugs to the leprosy patients through their centers and for providing follow up treatment to the leprosy patients. Circular should also be sent to the district health training centres to include leprosy while orientation training of any category of GHC staff is organized. Vertical leprosy staff from the districts should be invited for giving training to GHC staff. Similarly circular be sent to all regional Health & Family Welfare training centres and to ISM Medical Colleges, Nursing Schools to include leprosy orientation training programme for all categories of health workers in their centres. Instructions should be sent to all district magistrates to fill up the vacancies of contract staff sanctioned under World Bank support and to utilize the funds released to districts societies for health education, orientation training etc.

Disability and Ulcer Care

Training for disability and ulcer care needs to be strengthened in all the districts of the country. States which have not completed disability care training of four core trainers for each district should complete the same early and submit the report to Leprosy Division so that additional funds can be given for

organizing further training of peripheral staff of the district. In each district the State Governments should identify one orthopaedic surgeon/general surgeon and one eye surgeon in district hospital as a nodal officer in the district who should be involved for training of field staff along with other four core trainers in the district. The name of identified surgeons should be circulated in all health centres of the district so that they can refer the patient to them. Names of surgeons identified in each district should be sent to Leprosy Division, Ministry of Health & FW for monitoring and supervision on disabilities and ulcer care activities.

Integration

Leprosy services will be required to integrate with GHC services after the end of 1998. Therefore, the process of integration must be started in a phased manner. To start with all the Health & FW training centres, district training centres and training centres under ISM are required to be instructed to include leprosy in the course curriculum for all categories of staff including for orientation training. The trainers can be involved from the locally available Leprosy Trained Medical Officer/Supervisors. Such trainers should be allowed to draw their TA/DA from the funds of District Leprosy Societies where they are working. Once the orientation training of 80% of staff is completed in the district with in next three years, the services can be integrated in the district after following the transfer of records, reports and case cards. This is however advisable to be done after verifying proper orientation training of atleast to 80 % of the staff.

Agenda Item No.XIX(i):

STATUS OF THE REPORT ON ENVIRONMENTAL HEALTH AND SANITATION

The outbreak of Plague in 1994 and the resurgence of Malaria and Dengue in some parts of the country has raised a serious concern with regard to the capability of the existing Public Health System in the country. The newly emerging and re-emerging health problems have been further accentuated by deteriorating environmental health conditions

A Committee under the Chairmanship Of Shri M.S. Dayal, former Union Health Secretary was constituted to formulate a comprehensive National Programme of Sanitation and Environmental Hygiene on he lines of technology mission for checking the fall in environmental standards.

The recommendations made by the Dayal Committee (1995) were discussed in a meeting of Committee of Secretaries (COS) and it was decided that action on the priority areas identified in the Dayal Committee report may be taken up by the concerned Ministries/Departments by including them in their Ninth Plan proposal. The concerned Ministries, viz., Urban Affairs and Employment, Environment and Forests and Rural Areas and Employment have been informed of the COS's decision for further necessary action.

The Dayal Committee had identified 6 priority areas for implementation during the Ninth plan by the respective Ministries. These are (a) urban low cost sanitation, (b) urban waste water management, (c) Urban solid waste management, (d) rural environmental sanitation, (e) industrial waste management, (f) air pollution control and (g) strengthening of health surveillance and support services.

The Working Group on "Environmental and Health; Health Education and IEC constituted by the Planning Commission under the Chairmanship of Secretary (Health) also examined issues related to Environmental Hygiene and Sanitation Out of 15 action points identified by the Sub-Group of Environment and Health, 7 points pertain to Ministry of Health & Family Welfare. These 7 identified programmes broadly relate to environmental health surveillance, water quality monitoring and surveillance, hospital waste management and sensitisation of Panchayats and Nagar Palikas for planning and implementation of environmental health activities at local level.

The 73rd and 74th Constitutional Amendment Acts, 1992 have provided a framework for involvement of Panchayat Raj and Nagar Palikas in all developmental programmes including public health and sanitation in the rural and urban areas of the country respectively. These local bodies would thus have a tremendous role to play in upgrading the environmental health condition. For effective implementation of health education activities in environmental health and sanitation, multi sectoral cooperation and coordination is necessary. The Central Health Education Bureau should function as the nodal agency at the Central level for health education, health awareness and community participation in environmental health andsanitation activities, Separate Committees at village, block, district ad State level need to be constituted with due representation from government and non-government agencies to monitor the health education and awareness activities at the respective levels.

None of the available laws in the country takes into consideration health and environment in a comprehensive manner. In view of this, constitution of an inter-ministerial working group comprising the Ministry of Environment and Forests and the Ministry of Health & Family Welfare has been suggested to examine the existing Environmental (Protection) Act, 1986 and the Model Public Health Act (Revised), 1978 and to frame a comprehensive Environment and Health (Protection) Bill for consideration of the Government. The Panchayati

Raj institutions and Nagar Palikas should also actively consider the model Public Health Act, 1978 for incorporating suitable provisions in their local health Acts,

The following points are for consideration and discussion in the meeting:-

1. Constitution of an inter- ministerial group to examine the existing laws of public health and environment and come out with appropriate recommendations to enforce proper safeguards in the implementation of development projects with due empowerment of local bodies.

2. Strengthening of the Department of Health and Directorate General of Health Services by establishing a Division of Environmental Health for proper management and control of environmental health issues.

3. The measures adopted by the Central Government on environment and health may be adopted by the State Governments also for framing suitable programmes in the area of environment , health and sanitation and include them in the Ninth Plan.

4. Sensitisation of Panchayat and Nagar Palikas is called for planning and implementation of environmental health activities and implementing health education activities through various Committees on a sustainable basis.

5. Appropriate schemes on drinking water quality monitoring and surveillance and hospital waste management need to be initiated.

HOSPITAL WASTE MANAGEMENT

Factors which have brought the problem of hospital waste management into sharp focus have been -

(a) The rapid increase in waste generated in hospitals mainly due to increasing use of disposables as compared to recyclable or reusable devices.

(b) The increase in complexity and technical advances in medical and surgical care resulting in a quantum increase in magnitude and complexity of waste generated from this activity. There has been a rapid mushrooming of health care facilities providing state-of-art, medical care. Unfortunately, at the same time, due attention has not been given to providing adequate infrastructure facilities including the safe management of waste generated.

(c) The problem has been compounded by rag-pickers who sift through waste and recycle certain elements for financial gains. Thus the recycling of bio-medical waste such as disposable syringes, intravenous tubes, catheters, surgical gloves, etc. has undermined the drive to make treatment of patients safer through the use of disposable products.

The following types of wastes are generated in the major hospitals in the country :-

i) Non-clinical or house hold waste;
ii) Clinical or biological waste;
iii) Solid, liquid waste and radio-active waste; and
iv) Chemical waste.

In most of the major hospitals under the Central Government and State Governments, incinerators have been installed for disposal of hospital waste. Most of these hospitals have also introduced a system of segregation of hospitals waste by use of different coloured plastic bags and destruction of infectious items such as disposal syringes and needles. But there are gaps in the system which has led to infectious items being thrown in refuse dumps and which are picked up by rag-pickers.

In April, 1995, the Ministry of Environment & Forests, promulgated the Draft Rules on Management of Bio-medical Wastes which provide for control over generation, handling, treatment and disposal of medical waste. The appropriate authorities have been designated with the task of implementation of these rules. All persons handling such wastes are required to obtain authorization from the appropriate authority.

A Schedule of Wastes has been listed to which these rules apply. The segregation of waste at sources has been made mandatory for all institutions dealing with these wastes. The rules also provide a general scheme for types of containers to be used, colour coding and labelling. Options for treatment and disposal are also provided in a broad way. An important feature is the prohibition on the import and export of bio-medical wastes. Biannual reports, maintenance of records and returns have been made mandatory.

The rules were circulated to all health care establishments and their comments invited. They are to be finalised by the end of 1996.

The Central Pollution Control Board (CPCB), has also developed guidelines for management of hospital wastes and standards for incinerators. According to the guidelines recommended by CPCB, the hospital wastes are to be segregated in different catogories and collection in colour-coded containers so as to avoid mix up of the wastes. The infectious wastes should be subjected

to incineration, while the needles, scalpel, blades, and discarded glasswares should be disinfected by autoclaving. CPCB has recommended two types of incinerators namely, for individual and common use.

Specification regarding temperature, emission levels, height of incinerator and liquid effluent characteristics have been laid down.

Presently, incineration is being utilised for disposal of medical waste. However, keeping in view the issues of environmental pollution, inherent problems of production of ash and toxic emission, alternative strategies for waste management need to be explored, such as :-

(a) Waste Reduction : A lot of emphasis is being given to reduce the amount of waste generated by return to recyclable devices. For example, use of glass syringes instead of plastic syringes, etc.

(b) Composting of organic faction of waste, particular trials are being made in the use of vermi-composting in various parts of India.

(c) Chemical processes which are eco-friendly.

(d) Auto-claving and mechanical shredding.

During the current year 1996-97 an amount of Rs. 10 lakh has been kept for initiating pilot projects on comprehensive waste management under the Health Sector.

Various aspects of Hospital Waste Management in the country were examined and a number of action points have emerged :

(i) Comprehensive technical and management guidelines need to be issued. Cost factors and economic considerations should be addressed in the guidelines.

(ii) Issue of instructions regarding the use of glass syringes after autoclaving. Regarding needles it is felt that since virus may not be destroyed, disposable needles could be used.

(iii) Emphasis should be placed on creating awareness, motivating and educating staff. Training programmes should be formulated.

(iv) It is necessary to prepare hospital waste manual which would cover the following points :

(a) Local collection of waste at site of waste generation.
(b) Segregation of waste at local site.
(c) Transportation of waste.
(d) Disposal of waste (including radio-active waste).
(e) Purchase of items such as shredders, coloured bags, needle destroyers, etc.
(f) Proper storage at the storage area of incinerator.
(g) Disposal of ash generated by the incinerator.
(h) Training of personnel handling waste.
(i) Clear demarcation of tasks to be performed by different personnel.
(j) Duties of supervisory staff.
(k) Instructions regarding protective clothing to be worn by personnel handling hospital waste and periodic health check-up of such personnel.
(l) Security requirement to prevent illegal re-cycling.

(v) Immunization of staff should be a priority.

(vi) Each State/UT should formulate its plan of action for hospital waste management and include this as apart of the State Plan discussion with the Planning Commission during the Annual Plan discussions for 1997-98.

It is urged that the Central Council of Health & FW take cognisance of the above stated facts relating to poor management of hospital waste and its adverse impact on human health and resolve initiation of Hospital Waste Management Programme during the Ninth Plan period.

STATUS REPORT ON RABIES INCLUDING USE OF ARS IN SEVERE BITES

Approximately 30,000 deaths occur due to Rabies every year in India and around one million persons take post-exposure treatment after dog bite, of which around 0.5 million take painful 14 injections in the abdomen of the Semple vaccine which is prepared in the sheep brain by 100 year old technology, only 0.5 million persons take more advanced, safer tissue culture vaccine for treatment which costs about Rs.2000/- per treatment. The nervous tissue vaccine which is produced in the country at times is not of good quality and the distribution in the States is not satisfactory (without proper cold chain) and in remote areas sometime the patients do not get vaccine. Similarly, anti-rabic serum which is given immediately after the bite to save the life of the patient is not available in many hospitals and centres in the States, thus leading to deaths in large number who are bitten by rabid dogs. Of late, the incidence of rabies has increased not only in the stray dogs, but also in vaccinated dogs (70% dogs developed Rabies). It has also been observed that a single rabid dog can bite 50-100 persons and cover 30-40 kms.

On the basis of the recommendations made at the Workshop on Surveillance and Control of Rabies in 1985, which was attended by representatives of States and UTs and National and International experts, initiation of a national Rabies control programme was recommended. However, same has not been implemented yet.

Anti-rabies vaccine production

In India, by and large, neural anti-rabies vaccine is being used which is manufactured in 12 public sector institutes. One of the public sector institutes

i.e. Pasteur Institute, Coonoor is also making efforts to produce Vero cell tissue culture vaccine which may be made available shortly. Another public sector undertaking is marketing tissue culture vaccine in small quantities. In private sector Hoechst (India), Mumbai is manufacturing tissue culture vaccine in limited quantity. Anti-rabies serum is being manufactured by Central Research Institute, Kasauli. In addition several institutes are involved in the production of veterinary vaccines, both neural and tissue culture origin.

Rabies Control Programme:

The Rabies control activities should be through:-

(a) Enhancing awareness among the general public through various print and electronic media.

(b) To reduce by humane methods maimed, obviously unhealthy and unowned dogs with the aim to reduce the dog population to 80% of the current population.

(c) To compulsorily vaccinate this 80% dog population with a potent tissue culture vaccine. The vaccine is to be administered free of cost.

(d) To effectively implement legislative measures for compulsorily licensing the owned animals.

(e) To provide pre-exposure tissue culture vaccine to persons engaged in control activities.

(f) To strengthen the existing diagnostic services in the country.

Adoption of modern techniques for production of anti-rabies tissue culture vaccine and phasing out the neural tissue vaccine.

To produce anti-rabies globulin through adoption of modern technologies.

Strict quality assurance of the anti-rabies vaccines being produced.

In view of the above it is urged that the Central Council of Health & FW take cognisance of the facts related to Rabies problem causing preventable mortality in man and animals and resolves to initiate Rabies control activities in the country

NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS

The performance of cataract operations and other eye care services needs to be improved in Government institutions viz. medical colleges, district hospitals, district mobile units and upgraded PHCs.

To increase the performance, it would be necessary to upgrade the targeted service units by filling up sanctioned posts of eye surgeons and paramedical staff, supply of consumable items by the State, training of personnel and support from PHC staff.

Funds released by Government of India are not efficiently utilized by the States leading to accumulation of unspent balances over the plan period. This not only hampers planned development of services in the State, but also adversely affects disbursement of funds from the World Bank and DANIDA. Delay in receipt of audited expenditure report slow down disbursements. These shortcomings affect further release of funds to the States.

The State should judiciously draw a realistic plan of action for development of services in each financial year well before the commencement of the financial year. This plan of action should take into account equitable distribution of eye care units in various districts of the State and should be drawn in a need-based manner. Timely and complete reporting of performance, development of services, component-wise expenditure and audit reports would enable Government of India to release funds to the States and seek assistance from the World Bank and DANIDA expeditiously. Proposals for revalidation of unspent balances, if any, should be sent to Government of India in the first

quarter of a financial year with details of component-wise savings, reasons thereof and manner in which funds are proposed to be utilized.

The State Programme Cell needs strengthening to monitor activities under National Programme for Control of Blindness including functioning of District Blindness Control Societies in the States.

Funds are currently released to DBCS from Central Govt. on a performance related basis, as recommended by Central Council of Health & Family Welfare in their previous conference, in October, 1993. The State should assume the responsibility of monitoring functioning of DBCS as per guidelines issued by Government of India. However, main features of DBCS as outlined in GOI guidelines including its autonomous character, constitution, composition, pattern of expenditure etc. should be retained. To strengthen State Programme Cell, the State Govt. should post full time State Programme Officer of Joint Director rank and requisite support staff as sanctioned under NPCB.

Utilization of available services, both in fixed facilities and eye camps is not optimal. The State Governments and respective District Blindness Control Societies should plan and implement effective IEC activities to improve awareness about eye care in general and treatment of cataract in particular, allay the misconceptions of public and inform availability of eye care services. IEC activities should target not only beneficiaries but also community leaders, Panchayat leaders, health staff and provide eye care services.

Implementation of NPCB include collaboration between Government and non-Govt. organizations. The State should extend full cooperation to NGOs in implementation of various schemes viz. organization of surgical eye camps(reach out approach), organization of screening camps and surgery at base hospital (reach- in approach) expansion of or setting up of eye care units in rural including tribal areas under World Bank assisted project, scheme for

screening and motivation and eye banks/eye donation centres in voluntary sector.

National Programme for Control of Blindness should be made comprehensive eye care programme rather than a cataract centred programme.

The States should expand activities like school eye screening for correction of refractive errors, eye donation and eye banking for reduction in corneal blindness, management of glaucoma and other eye disorders. Follow up of operated cases and provision of corrective glasses should also be emphasized.

Additional activities under World Bank assisted project including construction of dedicated eye operation theater, eye wards and dark rooms at PHCs, schemes for cost recovery, training of district eye surgeons in IOL surgery etc. should be undertaken. Additional posts under the project should be created and filled by regular or temporary posts, through redeployment or through contractual appointment.

NATIONAL CANCER CONTROL PROGRAMME

It is estimated that there are 2.0 million cancer patients at any given point of time and about seven lakh new cases come up every year in the country. The disease has high morbidity and mortality.

The Govt. Of India started the Cancer Control Programme on a limited scale during the year 1975-76. There are schemes for

(i) Grant-in-aid to Regional Cancer Centres

(ii) Financial assistance for setting up of Cobalt Therapy Units

(iii) Development of oncology wings in medical colleges/hospitals.

(iv) District Project for health education, early detection and pain relief measures

(v) Financial assistance to voluntary organisations for health education and cancer detection activities.

The Plan funds for National Cancer Control Programme during The two years are as follows:-

1995-96	Rs. 16.00 crores
1996-97	Rs. 18.00 crores

The points for discussion are:

(a) Increase in Plan funds for strengthening of the programme and wide coverage.

(b) Possibility of alternative sources of funding the programme so as to augment the availability of resources. A Society may be formed which may raise donations and loans apart from Central funding.

(c) The emphasis should be on comprehensive cancer centres for prevention, diagnosis, treatment, pain relief and research activities. Thin spreading of resources may not be desirable.

(d) Emphasis on one time grants rather creating recurring liabilities under the programme.

(e) Regional Cancer Centres may increase their own resources so as to reduce their dependence on Government Grants.

(f) There is a scheme for development of oncology wings in medical colleges/hospitals. More institutions may be covered under the scheme for augmentation of treatment facilities in the country.

(g) Larger involvement of voluntary organisations in the programme particularly for health education and cancer detection activities. Financial assistance may be provided to such organisations in consultation with the concerned State Governments.

NATIONAL IODINE DEFICIENCY DISORDERS CONTROL PROGRAMME

MAGNITUDE OF THE PROBLEM:

As per information available more than 1.5 billion population of the World are at the risk of Iodine Deficiency Disorders(IDD) out of which, it is estimated that about 200 million people are living in our country. The survey conducted by the Central & State Health Directorates, ICMR and medical institutes have clearly demonstrated that not even a single State/UT is free from the problem of Iodine Deficiency Disorders. Sample surveys have been conducted in 25 States and 4 Union Territories of the country which have revealed that out of 269 districts surveyed so far, IDD is a major public health problem in 235 districts.

CONTROL PROGRAMME:

Realizing the magnitude of the problem the Government of India launched a 100 per cent Centrally assisted National Goitre Control Programme(NGCP) in 1962. The important objectives and components of the control programme are as follows:-

(I) Surveys to assess the magnitude of the Iodine Deficiency Disorders.

(ii) Supply of iodated salt in place of common salt.

(iii) IDD Monitoring through analysis of salt and Urine samples.

(iv) Resurveys to assess Iodine Deficiency Disorders and the impact of iodated salt after every 5 years.

(v) Health Education.

In August, 1992 the National Goitre Control Programme(NGCP) was renamed as National Iodine Deficiency Disorders Control Programme(NIDDCP) considering the wide spectrum of Iodine Deficiency Disorders.

ACHIEVEMENTS:

The achievements made under the major components of the existing programme from its inception to date are as under:-

(i) The policy of iodated salt production has been liberalized to private sector. 641 private manufacturers have been licensed by Salt Commissioner out of which nearly 532 units have commenced production so far. They have annual production capacity of more than 60 lakh tonnes for the entire country.

(ii) The annual production of iodated salt has been raised from 5 lakh metric tonnes in 1985-86 to 34 lakh metric tonnes in 1995-96. This is expected to further rise to 50 lakh metric tonnes in near future.

(iii) The Salt Commissioner in consultation with the Ministry of Railways arranges for the transportation of iodated salt from the production centres to the consuming States under priority category 'B' a priority second to that for defence. Funds are provided to Salt Commissioner's Office for maintaining the quality control of iodated salt at production level.

(iv) To ensure use of only iodated salt, the sale of non-iodated salt has been completely banned under Prevention of Food Adulteration Act, 1954, in 22 States and 5 Union Territories and partial in 2 States namely Andhra Pradesh & Maharashtra. There is no ban in the State of Goa, Kerala and Union Territory of Pondicherry.

(v) For effective monitoring and proper implementation of NIDDCP all the States and UTs have been advised to establish IDD control Cell in the State Health Directorate and Central Government provides cash grants for this purpose. Presently 27 States and Union Territories have established such type of Cells.

(vi) A National Reference Laboratory for monitoring of IDD has been set up at the Bio-chemistry division of National Institute of Communicable Diseases, Delhi for training medical and paramedical personnel and monitoring the iodine content of salt and urine.

(vii) It has been proposed to set up district level IDD monitoring labs for iodine content of salt and urinary iodine excretion which are the most effective tools for proper implementation of IDD Control Programme. For the year 1996-97 budget provision has been made for setting up of at least one IDD Monitoring Laboratory in each State/UT.

(viii) Cash grants are provided by the Central Government for conducting surveys/resurveys of IDD; Health Education and Publicity Campaign to promote the consumption of iodated salt.

(ix) The standards for iodated salt have been laid down under PFA Act, 1954. These stipulate that the iodine content of salt at the production and consumption level should be at least 30 and 15 ppm respectively.

(x) Realising the importance of iodine deficiency in relation to Human Resource Development, NIDDCP has been included in the 20 Point Programme of the Prime Minister.

(xi) For ensuring the quality control of iodated salt at consumption level, testing kits for on the spot qualitative testing have been developed and distributed to all District Health Officers in endemic States for awareness.

(xii) GOI-UNICEF Project 1992, 1993-1995, is being implemented in 13 selected endemic States for extensive monitoring and IEC activities of NIDDCP. The activities are to be strengthened in 106 selected districts of 13 States including North-Eastern region. The project is also extended for the year 1996-97.

POINTS FOR CONSIDERATION OF CENTRAL COUNCIL OF HEALTH & F.W.

The major problems/action points of the programme for consideration of the Council are as follows:-

(a) To issue complete ban notification by the remaining States/UTs for the sale of non-iodated salt.

(b) To establish IDD Control Cell by remaining States/UTs.

(c) To set up district IDD Monitoring Laboratories for estimation of iodine content of salt by titration methods and urinary iodine excretion by the remaining States and UTs. The Laboratory personnel should be trained at National Reference Laboratory for IDD monitoring at NICD Delhi. Complete guidelines, including collection of samples from periphery, should be provided to the Laboratory personnel.

(d) To enforce the quality control of iodated salt supplied to the consumers by the State/UT Governments.

(e) To conduct IDD surveys in remaining districts.

(f) To create awareness about IDD and consumption of iodated salt for their prevention.

(h) To develop trained medical and paramedical personnel for implementation of NIDDCP

MENTAL HEALTH PROGRAMMES-HIGHLIGHTING DISTRICT COMPONENT

Mental Health problems have become a major public health problem in recent times. Epidemiological surveys within the country have revealed that 5-10% of general population are in need of psychiatric care at any given time and also the most of them seek help through a general health facility for some physical problems. General Practitioners are not sufficiently trained to detect and manage these problems in their day to day practice.

The number of qualified mental health professionals is very small and added to this is that most of them are concentrated in big cities. About 50 mental hospitals in the country are in a deplorable state to the extent that Supreme Court had to ask the Central Government to intervene in at least five of them. There are no mental health services or are only at a rudimentary level in some States/U.T.s particularly in M.P., H.P. and in North East Region. Lack of Psychiatric services at the periphery, lack of proper knowledge about mental illness and their causes, myths, misconceptions and stigma surrounding mental illness all result in untold suffering to the patients and their families calling for a community based approach towards tackling mental health problems in the country.

National Mental Health Programme (NMHP) though in existence since 1982 failed to take off due to various reasons. After taking a decision to revamp and revitalise the programme in the last Central Council of Health & Family Welfare meeting, a National Workshop of State Health Administrators was held at Indian Institute of Management, Bangalore in February, 1996, to give direction to the NMHP. One of the major recommendations of the Workshop was to adopt community based approach in implementation of the NMHP in at least 25% of the Districts in all the States of the country in the next Five Year Plan. Parliamentary Standing Committee on Human Resource Development in its latest Report (45th Report) has also emphasised that mental health services need to be extended to all the districts of the country on priority and

recommended appropriate increase in funding to achieve this target.

The District Mental Health Programme envisaged under NMHP will be taken up with central assistance. As envisaged it will first be run on a pilot basis in a few States on the model developed and successfully tried by NIMHANS, Bangalore in Karnataka in the district, Bellary known as 'Bellary Model". Training facilities for doctors, nurses and other workers required for the District Mental Health team will be provided by identified institutions in the States. These nodal institutions swill provide the necessary technical back-up from time to time for developing and running the programme in district. Monitoring of the programme will be done by the State through the nodal institutions and by the Centre. District Mental Health team is expected to provide service to the needy mentally ill patients including persons suffering from epilepsy and their families through Out-Patient Service, ten bedded in-patient facility, referral service, liaison with PHC and follow up service. The programme also aims at creating awareness in the community to remove stigma of mental illness.

Indian Lunacy Act, 1912 has been replaced by Mental Health Act, 1987 and is in force since April, 1993 in all the States and UT's. As per provisions under this Act, in addition to setting up of a Mental Health Authority in their respective States and UT's, Mental Health Authority so established will take necessary steps to ensure development and regulation of delivery of Mental Health Services as per norms provided under the law.

The following points are for consideration and discussion :

General issues

(a) In future, as a matter of policy, mental health may be integrated with physical health as part of planning of health services in the country both in States and the Centre. Peripheral services at the District and Sub-district level have to be accorded due priority in planning.

(b) Medical Council of India may be appropriately involved in improving the undergraduate curriculum and training and also through introducing refresher courses to update the knowledge and experience of practising physicians.

(c) Improvement of mental hospitals and Departments of Psychiatry in general and teaching hospitals in terms of adequate staff and services in all the States needs urgent attention.

District Mental Health Programme

(d) States must take advantage of the training programmes of trainers offered by the Centre through specialised institutions such as NIMHANS. They must in turn undertake training programmes of other functionaries like PHC Doctors, Nurses, Voluntary Social Workers, Anganwadi Workers, Community Health Workers, Teachers and family members of patients etc. so that patients can be managed at the periphery itself within the community.

(e) Appropriate IEC materials in all local languages may be developed for the use of doctors and paramedics and the public to create awareness about the disease and the much needed acceptance of the mentally ill in the society.

(f) The States must provide adequate and regular supply of medicines meant for mental illness etc. to the District and sub-District Health Centres.

(g) More training institutes have to be identified in the States so that needs of the District Mental Health Programme may be met with even in those States which lack manpower resources.

(h) With the recognition and inclusion of disability arising out of Mental illness as one of the disabilities eligible for benefits under the provisions in the new Disability Act, 1955, rehabilitation of the mentally ill and their acceptance within the community is an important area needing urgent attention by the States

State Mental Health Authorities

(1) Those States and U.T's which have not yet formed or notified the Mental Health Authority may do so at the earliest as establishment of Mental Health Authority is the statutory requirement for every State & U.T. Once they start functioning properly it will result in overall improvement in delivery of Mental Health Services.

ROLE OF HEALTH SECTOR IN IMPLEMENTATION OF PROGRAMMES FOR PERSONS WITH DISABILITIES (EQUAL OPPORTUNITIES, PROTECTION OF RIGHTS AND FULL PARTICIPATION)

It is to be noted that Act has come into force w.e.f. 7-2-1996 and is an important landmark in the empowerment of persons with disability through creation of equal opportunities and protection of their rights. Disabilities as per this Act include (a) Blindness (b) Low Vision (c) Leprosy Cured (d) Hearing impairment (e) Locomotor disability (f) Mental retardation and (g) Mental illness. Even though Ministry of Welfare is the nodal Ministry directly concerned with rehabilitation of the disabled, Ministry of Health and Family Welfare plays an important role in early detection and prevention of disability and has a number of National Health Programmes in this connection. They are - (i) Leprosy Eradication Programme (ii) Blindness Control Programme (iii) Iodine Deficiency Disorders Control Programme and (iv) National Mental Health Programme . Besides these, the Universal Immunisation Programme and Maternal Child Health Programmes have a direct bearing on prevention of disabilities. There is a further need for development of inter-sectoral co-operation and collaboration between various concerned Ministries, between Government and N.G.O. Sectors and between Centre and States in the area.

Following Points are for consideration

1. District Level Centres of Rehabilitation:

Health infrastructure in terms of PHC and District and Sub-District Centres at the periphery already exits and can be advantageously used in the present context for incorporating various aspects of prevention and rehabilitation.

2. Mental illness:

As mental illness has also come under the purview of the Act. It has

become all the more necessary to give further impetus to the National Mental Health Programme with special emphasis on rehabilitation of mentally ill and their acceptance back in the community. Task of assessment and grading of disability arising out of mental illness has to be undertaken like in physical disability so that they are able to take advantage under the provisions of the Act.

3. Employment:

It need to be emphasised that 3% reservation for persons with disability in jobs in Governments and Public Sector Undertakings is an extremely important provision of this Act. and has to be quickly implemented by all concerned including the Department of Health & Family Welfare in various States and U.T.'s. The special employment exchange should take care of this provision in the Act.

4. Research:

Nation-wide surveys, investigations and research concerning the causes of occurrence of disabilities and their prevalence in the community needs to be undertaken if necessary in collaboration with other concerned Ministries like Welfare. Also research needs to be undertaken in the development of newer aids and devices and other cost effective socio-culturally acceptable methods of delivery of rehabilitation services within the country.

5. Establishment of Special Institutions or Identification of already existing institutions :

The two special institutions dealing with disability under the Ministry of Health & Family Welfare are:

1. All India Institute of Physical Medicine & Rehabilitation, Mumbai,
2. All India Institute of Speech and Hearing, Mysore. Besides there are departments of rehabilitation attached to hospitals. All these can be further strengthened. In the field of mental health, already existing institutions of National character. like NIMHANS, Bangalore, CIP, Ranchi and IHBAS, Delhi can be assigned key roles to develop cost effective models of rehabilitation services for the mentally ill. There is need for

collaboration between various institutions run by other Ministries like Ministry of Welfare, Labour , Education and the NGO's in the field. Rehabilitation thus will be a collaborative effort.

6 Training Programmes:

Already existing training programmes under the various health programmes have to cooporate and lay more stress on Preventive and Rehabilitative aspects. There is also a need to develop suitable training capsules in regional languages to transfer the technology at the grassroots level of workers in the field. Appropriate training programmes have to be organised for training the PHC/CHC Doctors and other paramedics with the assistance of specialised institutions in the area of Rehabilitation.

7. Public Awareness Campaigns

These involve undertaking of IEC activities using the various available methods of communication and media. It is to be noted that there is a lot of stigma attached to certain illness like Leprosy and mental illness. Myths, misconceptions and prejudices surrounding these illnesses are a hindrance to the rehabilitative efforts.

Correct and proper education about these illnesses need to be undertaken and disseminated on a war footing to result in change of attitude.

REGULATORY MEASURES FOR PRIVATE NURSING HOMES

Problem

There are a great number of private and voluntary hospitals in the country and several of them are running without qualified doctors, without adequate equipment and infrastructure. In addition many of those private nursing homes/hospitals dump hazardous hospital waste in residential areas. The National Human Rights Commission is considering the issue from the point of view of human rights and has sought to know if any regulation has been framed to regulate the functioning of private hospitals. It has also been observed that there was no categorisation for grading private hospitals with the view to enabling the public to have readily available information of facilities with those hospitals. Only a few States have enacted legislation.

Laws enacted by State/U.Ts. to regulate private nursing homes/hospitals

To regulate the functioning of the private hospitals, the Delhi Nursing Home Registration Act, 1953 had been enacted to provide for registration and inspection of nursing homes in the N.C.T. of Delhi. The Bombay Nursing Home Registration Act, 1949 has been enacted by the Government of Maharashtra to provide for registration and inspection of nursing homes in Maharashtra. The Government of Andhra Pradesh, Karnataka and Uttar Pradesh are in the process of making similar legislation.

Brief Provisions of Delhi Nursing Home Act

The Delhi Nursing Home Registration Act, 1957 and the rules framed there under provide for registration and inspection of nursing homes in the N.C.T. of Delhi. This Act provides that no person shall carry on a Nursing Home without registration and the nursing home is required to have qualified medical practitioners and qualified nurses amongst others. In case of a maternity home, it should have qualified mid-wives and qualified medical practitioners. The construction, accommodation of any premises used for a nursing home should be fit to be used for a nursing home. The Government of N.C.T. of Delhi can cancel the registration in respect of a nursing home on the grounds of violation of provisions of the Act. The Act also provides for penalty for non-registratiion and imprisonment for a term which may extend to three months.

Citizens' Charter Mark Scheme

The Ministry of Civil Supplies and Consumer Affairs and P.D. has formulated a Citizens' Charter Mark Scheme for private as well as Government hospitals to recognise and reward excellence in delivery of public service and to promote improvement in public health services. It is a voluntary scheme. The providers of public utility scheme will be invited to apply for Charter Mark - a Special Logo, that signifies that the particular service has adopted the charter principle. The concept of charter marks scheme has been borrowed from the U.K. model. However it has been adopted to the Indian situation. The Citizens' Charter Mark can be provided to those who provide the required services. Hospitals desireous of having a charter mark should have the following facilities:-

(1) X-ray, Tilted X-rays, Portable X-rays, Testing Labs., Ultra Sonogram, 3-T Scan, Whole body scan, Treadmill, E.C.G., E.E.G., Echo-cardiogram, Physiotherapy equipment.

(2) Should offer centralisd air-conditioned rooms, intensive care unit where 24 hours nursing attention is provided.

(3) A duty doctor is available throughout 24 hours.

(4) 24 hours electricity/generator, 24 hours water supply is available.

(5) Engineers and technicians ensure 24 hours working of electronic and mechanical equipments.

(6) The list of doctors on duty are displayed outside.

(7) Canteen facility is available to provide hygienic food.

(8) The hospital is open 24 hours and emergency cases are attended to on priority.

(9) The hospital has a pharmacy which is open 24 hours.

(10) Telephone and STD facilities are available. The hospital has a telephone exchange with 10 lines.

(11) Indoor patients will be provided with clean beds, bedsheets and kept in hygienic environment, etc.

The implication of the Citizens' Charter Marks Scheme was examined in the Ministry of Health and F.W. It was noted that the parameters of the Scheme would entail almost quadrupling the strength of the hospital staff, and heavy investment in other infrastructure for which there are no resources available either with the Central Government or the State Government, except at the cost of disease control programes and public health measures, which are their primary responsibility.

The Dte.G.H.S. after considering the Citizens' Charter Mark Scheme had concluded, inter-alia, as under:-

(1) Health is a State subject and the State Government hospitals and private hospitals are regulated by the State Governments. The Central Government only lays down broad policies, and facilitates adoption of various measures for improvement of health services.

(2) An elaborate machinery would be required for examining the applications under the proposed charter and for conducting inspections. According to Government statistics, there were 4235 Government hospitals, 9457 private and voluntary hospitals, 2401 Community Health Centres and 21,802 Primary Health Centres.

(3) There are a multiplicity of practitioners practising in different systems under Allopathy, Siddha, Ayurveda, Homoeopathy and Unani but the facilities mentioned in the scheme relates to the allopathic system only.

(4) The question of enforcing time limits is not realistic as the infrastructure/support is weak. Government doctors in major hospitals hardly get 2-3 minutes to attend to a patient as they cannot turn away anybody who reports at the hospital or a specific unit. Having no control over the numbers reporting, the only way the situation can be remedied is to multiply the number of attending doctors, which has financial implications and need sufficient budgetary provision.

(5) The State Governments have inadequate enforcement staff to ensure adequate deployment of resources, drugs, consumables, working equipments, staff to adhere to the standards in private hospitals.

(6) The Charter would have very limited applications as facilities like ultra sonogram, C.T. Scan, Whole Body Scanner, Treadmill, EEG, etc. do not exist in most hospitals.

Australian System of Accreditation

This Ministry on the other hand has been considering the idea of adopting the Australian system of Accreditation under which professional associations like the Association of Surgeons, Physicians, Paediatricians, Gynaecologists, etc. meet on a common professional platform to give a star rating to hospitals according to the facilities they provide. They obtain registration charges for the annual inspection and award a star rating on the lines of hotel classification being done by the

Ministry of Tourism. The system appears to be more relevant to our needs since this will provide for private hospitals to be assessed by a peer review voluntary group and accredited based on facilities provided.

POINTS FOR CONSIDERATION

(1) Laws may be enacted on the lines of Delhi Nursing Homes Registraion Act, 1953 and Bombay Nursing Homes Registration Act, 1949 to provide for registration of private hospitals which have the minimum facilities for different forms of treatment and grading them on the basis of facilities available and services provided.

(2) A monitoring mechanism should be available to ensure that the facilities and services created are maintained at the desired level and continue to be available.

(3) Private hospitals in non-conforming areas which are posing health hazards should be shifted to other areas.

(4) Introduction of voluntary system of accreditation based on peer group assessment.

IMPROVEMENT OF EMERGENCY SERVICES IN GOVERNMENT HOSPITALS

The emergency/casualty is the first encounter of the patient with the hospital and there are a range of facilities which have to be provided to ensure that he gets the best possible attention in the shortest possible time before he can be shifted to the ICUs, specialised centres or wards.

In the case of Paschim Banga Khet Majdoor Samiti vs. State of West Bengal and anothers The hon'ble Supreme Court of India in its judgment dated 6th May, 1996 has suggested remedial measures to ensure immediate medical attention and treatment to persons in real need. The State Government of West Bengal had appointed an Enquiry Committee headed by a retired judge who gave recommendations, inter-alia, on measures that should be taken to ensure immediate medical attention and treatment to critical patients. The Committee had made the following recommendations in this regard:

(i) The Primary Health Centres should attend the patient and give proper medical aid, if equipped.

(ii) At the hospitals the Emergency Medical Officer, in consultation with the Specialist concerned on duty in the Emergency Department, should admit a patient whose condition is moribund/serious. If necessary the patient concerned may be kept on the floor or on the trolley beds and then loan can be taken from the cold ward. Subsequent necessary adjustment should be made by the hospital authorities by way of transfer/discharge.

(iii) A Central Bed Bureau should be set up which should be equipped with wireless or other communication facilities to find out where a particular emergency patient can be accommodated when a particular hospital find itself absolutely helpless to admit a patient because of physical limitations. In such cases the hospital concerned should contact immediately the Central Bed Bureau which will communicate with the other hospitals and decide in which hospital an emergency moribund/serious patient is to be admitted.

(iv) Some casualty hospitals or Traumatology Units should be set up at some points on a regional basis.

(v) The intermediate group of hospitals, viz., the District, the Sub-Divisional and the State Government Hospitals should be upgraded so that a patient in a serious condition may be given treatment locally.

The recommendations of the Committee have been accepted by the State Government and the Government of West Bengal in its memorandum dated August 22, 1995 issued the following directions for dealing with patients approaching health centres/O.P.D./Emergency Departments of hospitals:

(1) Proper medical aid within the scope of the equipments and facilities available at Health Centres and Hospitals should be provided to such patients and proper records of such aid provided should be preserved in office. The guiding principle should be to see that no emergency patient is denied medical care. All possibilities should be explored to accommodate emergency patients in serious condition.

(2) Emergency Medical Officers will get in touch with Superintendent/Deputy Superintendent/Specialist Medical Officer for taking beds on loans from cold wards for accommodating such patients as extra-temporary measures.

(3) Superintendents of hospitals will issue regulatory guidelines for admitting such patients on internal adjustments amongst various wards and different kinds of beds including cold beds and will hold regular weekly meetings for monitoring and reviewing the situation. A model of such guidelines would be suitably amended before issue according to local arrangement prevailing in various establishments.

(4) If feasible, such patients should be accommodated in trolley beds and, even, on the floor when it was absolutely necessary during the exercise towards internal adjustments as referred to at (3) above.

Having regard to the drawbacks in the system of maintenance of admission registers of patients in the hospitals it has been directed that the Superintendents and Medical Officers of the hospitals should take the following actions to regularise the system with a view to avoiding confusion in respect of Admission/Emergency Attendance Registers:

(a) Clear recording of the name, age,sex, address, disease of the patient by the attending medical officers;

(b) Clear recording of date and time of attendance/examination/admission of the patient;

(c) Clear indication whether and where the patient has been admitted, transferred, referred;

(d) Safe custody of the Registers;

(e) Periodical inspection of the arrangement by the superintendent;

(f) Fixing of responsibility of maintenance and safe custody of the Registers.

With regard to identifying the individual medical officers attending to the individual patient approaching Out Patients' Department/Emergency Department of a hospital on the basis of consulting the hospital records, it has been directed by the honourable court that the following procedure should be followed in future:

A. "A copy of the Duty Roaster of Medical Officers should be preserved in the office of the Superintendent incorporating the modifications done for unavoidable circumstances;

B. Each Department shall maintain a register for recording the signature of attending medical officers denoting their arrival and departure time;

C. The attending medical officer shall write his full name clearly and put his signature in the treatment document;

D. The Superintendent of the hospital shall keep all such records in safe custody;

E. A copy of the ticket issued to the patient should be maintained or the relevant data in this regard should be noted in an appropriate record for future guidance.

It is appreciated that Hospital Superintendent/Medical Officers-in-charge may have difficulty in implementing these guidelines due to various constraints at the ground level and, as such, feed back is vital to enable Government to refine and modify the order as will ensure a valid working plan to regulate admission on a just basis. Detailed comments and, therefore, requested with constructive suggestions."

The honourable Supreme Court is also of the view that in order that proper medical facilities are available for dealing with emergency cases it must be that:

1. adequate facilities are available at the Primary Health centres where the patient can be given immediate primary treatment so as to stablize his condition;

2. Hospitals at the district level and Sub-division level are upgraded so that serious cases can be treated there;

3. Facilities for giving specialist treatment are increased and available at the hospitals at District level and Sub-division level having regard to the growing needs.

4. In order to ensure availability of bed in an emergency at State level hospitals there is a centralised communication system so that the patient can be sent immediately to the hospital where bed is available in respect of the treatment which is required.

5. Proper arrangement of ambulance is made for transport of a patient from the Primary Health Centre to the District Hospital or Sub-Divisional hospital and from the District hospital or Sub-Divisional Hospital to the State hospital.

6. The ambulance is adequately provided with necessary equipment and medical personnel.

7. The Health Centres and the hospitals and the medical personnel attached to those Centres and hospitals are geared to deal with larger number of patients needing emergency treatment on account of higher risk of accidents on certain occasions and in certain seasons.

The Government of West Bengal was party in the proceedings of the court. Also, Union of India was a party. The honourable court has directed that other States should also take necessary steps in the light of the recommendations made by the Committee, the directions contained in the Memorandum of the Government of West Bengal dated 22nd August, 1995 and directions given by hon'ble court.

The judgement of the apex court has been sent directly by the Registrar of the hon'ble Supreme Court to State/U.T. Governments for compliance.

OTHER MAIN REQUIREMENTS

(I) Establishing round-the-clock Central Room with a C.M.O. having imprest funds for shouldering petty unforeseen expenses.

(ii) Availability of specialists on call provided through long distance pagers;

(iii) Establishing suitable specialised emergency services of surgeons/physicians/anaesthetists for providing round the clock services in the emergency block. For this, posts will have to be created as the present practice of leaving this important function to interns and residents is neither safe nor advisable.

(iv) Improving patient transportation by providing colour coded trolleys, wheel-chairs, ambulances;

(v) Improving man-power support by hiring private uniformed staff for transporting the patients and maintaining sanitation;

(vi) Bringing the emergency services for injuries, fractures, etc. within the main casualty block; and

(vii) Licensing a twenty-four hour drug shop and a small grocery store selling essential patient utensils, bed-pans, hot water bottles and other 'first day' needs near casualty.

POINTS FOR CONSIDERATION

1. The Central Government is taking necessary steps to improve the emergency facilities in the Central Government hospitals in Delhi. The State Government/U.Ts. may also take similar necessary steps to improve the emergency services facilities in State Government hospitals and consider making necessary provisions in their State Plans for this purpose.

2. The State Governments may take necessary remedial measures as per the apex court judgement to ensure immediate medical attention and treatment to the persons in real need, approaching health centres/O.P.D./Emergency Departments of the hospitals.

3. The State Governments may consider issuing instructions on the lines issued by the State Government of West Bengal to ensure that immediate medical attention is provided to patients in real need of treatment.

NATIONAL AND STATE ILLNESS ASSISTANCE FUND

The proposal to create a National Catastrophic Illness Assistance Fund has been under consideration of Ministry of Health & Family Welfare during the Eight FiveYear Plan. A note was circulated to all the appraising agencies during March 1996. Since Planning Commission were of the view that no new schemes should be started at the fag end of the Eight Five-Year Plan, it was decided to bring up this scheme on the Non-Plan side, instead of deferring it to Ninth Five-Year Plan.

The genesis of this Fund is a recommendation in the 31st Report of the Department relating Parliamentary Standing Committee on Human Resource Development which expressed concern about inadequate facilities for treatment of poor patients for major illnesses, especially those involving various complicated procedures. The Committee had recommended that it was essential to explore all appropriate sources of funds to assist poor patients coming to AIIMS or other Central Government hospitals for treatment of specific life threatening illnesses. The Committee had further suggested that a National Fund could be set up in which resources could flow from all sources, including private charities and international agencies and organisations.

This sentiment was echoed by Hon'ble Prime Minister at the concluding session of Chief Ministers held on 5th July, 1996. As a sequel to this, the Finance Minister made a specific mention of a scheme to raise the National Illness Assistance Fund for which a budget provision of Rs.5.00 crores was made in the Budget Estimates of 1996-97. The Fund could be subscribed by private individuals, corporate bodies in private or public sector, philanthropic organisations, national

or international and contributions made to this Fund were to be exempt from payment of income-tax. A similar proposal was made for raising similar Funds at the State level for which a Central Govt. assistance to an extent of Rs. 25.00 crores during 1996-97 has also been made in the Budget Estimates. Since the provision of Fund has been made under Non-Plan, it was decided to submit a detailed scheme for activating the fund to Committee on Non-Plan Expenditure.

Primary objective of the Fund is as under :-

(1) to provide assistance to poor persons below the poverty line of the UTs without legislature in getting specialised treatment for life threatening illness and treatment for injuries caused by industrial accidents, accidents occurring while handling agricultural machines and implements, bomb-blasts, natural calamitties, etc, as a one-time grant; and

(ii) to provide assistance to patients from anywhere in the country on the recommendations of the State Governments/UT Administrations in cases where the treatment cost exceeds Rs.1.50 lakhs.

The proposal was discussed in the Committee on Non-Plan Expenditure in its meeting held on 17.10.1996. The proposal to set up a National Illness Assistance Fund was approved, subject to the following conditions:-

(I) The National Illness Assistance Fund is registered as a Society under the Societies Registration Act.

(ii) In respect of foreign contributions, clearance from MHA under foreign contribution (Regulation) Act, 1976, is obtained.

(iii) Government hospitals may be given preference for the purpose of this Fund.

(iv) Government hospitals/Institutions which have availed of the facility of customs duty exemption for the import of equipment also be asked to participate in the scheme

(v) The UTs without legislatures will be authorised to sanction cases upto a ceiling of Rs. 1.50 lakhs for each individual case; the overall budgetary ceiling under the National Illness Assistance Fund for each Management Committee and communicated to the UT concerned.

(vi) In case where treatment costs exceeds Rs. 1.50 lakhs, the Management Committee would sanction cases on the recommendation of State /UT Governments on first come first served basis and maintain applications received in chronological order.

(vii) The Central Government grant would be utilised for providing treatment to the poor; however, efforts would be made to build up a corpus of the Fund.

The proposal for providing assistance to State for setting up a similar Fund was also approved, subject to the following conditions:-

(I) The Central Government will make contribution to the extent of 50% of the contribution made by the State Governments towards State Fund/Society or Rs. 5 crores in respect of States with large number and percentage of population below the poverty line, namely, Andhra Pradesh, Bihar, Karnataka, Madhya Pradesh, Maharashtra, Orissa,

Rajasthan, Tamil Nadu, Uttar Pradesh and West Bengal and maxiumum of Rs. 2 crores to other States/UTs with legislatures, whichever is less, in a year.

(ii) The State government will have to furnish proof of the constitution of State Fund as a Registered Society for availing assistance from the Central Government.

(iii) The bye-laws of the State/Society should adhere to the objective of providing medical treatment to the poor below the poverty line.

(iv) The contribution of the Central Government towards the State Medical Relief Fund would be kept in the fund of the Registered Society which would be outside the State Government Funds.

In accordance with the approval of the Committee on Non-Plan Expenditure, all Chief Secretaries have been apprised of the scheme.

The fund will be activated very soon.

The matter is also placed before CCH&FW for information.

STRENGTHENING OF DRUGS/VACCINE/FOOD QUALITY CONTROL

I. DRUG CONTROL

It had been agreed in the last Central Council of Health Meeting held on 11-13, October, 1995 (Resolution No. 2, Page 33 of Proceedings) that the drugs enforcement set up be strengthened both at the Centre and in the States, and the capacity of drug testing in the analytical laboratories be augumented. The Ministry of Health is negotiating with the World Bank for funding a project which aims to attain the above objectives.

Presently, a central scheme providing 100% financial assistance to the State Governments for setting up drug testing laboratories is in operation during Eight Five Year Plan. Under this scheme, upto Rs. 7 crores was made available to the States and many States benefitted from this funding. However, this scheme did not envisage creation of additional posts in the laboratories and only covered cash assistance towards the purchase of equipments, accessorries and laboratory chemicals.

Two National Consultants, appointed by WHO to assist the Drugs Controller General (India), recently visited most of the State laboratories to ascertain the actual requirements of each laboratory to increase the capacity to conduct drug testing with the required improvement in the quality of testing. They have identified the equipments and the manpower requirements of each laboratory and have

indicated that sophisticated equipments may improve the qulity of testing but the improvement in capacity can be made only with the addition of laboratory workers and the support of appropriate funds towards running expenses.

A 50:50 expense sharing scheme for increase in Drug Inspectorate staff included in the Eighth Plan proposal never took off as funds could not be made available for the same by the Planning Commission. Recognising the need to increase the enforcement staff - both at the Centre and in the States - the project under formulation for obtaining World Bank assistance includes a 100% assistance scheme to strengthen the enforcement staff in the State Drug Control Organisations. The National Consultants have also worked out the requirements of the States who have expressed an interest to participate in this component of the World Bank funded project. Some States have not indicated any interest in this subject.

A condition for participating in the project is the State's commitment to sustain the scheme at the close of five year project period. This would imply that the salaries of all the additional posts created under the project and the recurring expenses to support the additional activities generated shall be accepted as a State liability by the participating States.

All State Governments are requested to agree to participate in this Project and confirm their willingness to sustain the project after the five year period upto which funding from the Centre will be available. This project would be in the larger health interest of the people of this country as it would help in providing modern testing and enforcement facilities so as to make quality and inexpensive drugs available to the poor people of our country.

II. VACCINES

The diseases for which drug resistance is already a matter of concern (Respiratory Infection, TB, STD and Malaria) account for a large number of deaths. Thus study/evaluation of drug resistance microbes pose a challenge for research and health care. Indigenous production of potent vaccines/drugs are to be encouraged, for instance, replacement of the Nervous Tissue Anti Rabies Vaccine by Vaccine based on Tissue Culture. Some institutions have shown interest in this line and they are to be supported through all possible ways including Operational Research. In addition, the manufacture of vaccine for Yellow Fever and Japanese Encephalitis have to be undertaken for which steps have to be taken to augment capacity and renovate and modernise the production units. The vaccine institutes should be provided adequate funds for producing/strengthening the capacity of the institutions for producing the vaccines as per needs. It is also desirable that there should be upgradation/modernisation of the technology wherever necessary.

III. Prevention of Food Adulteration Act, 1954 (Aims & Objectives)

Food Safety through Food Quality Control Programme is of paramount importance in achieving the goal of "Health for all" by 2000 A.D. It can be achieved through the combined efforts and cooperation of food industry (self disciplined programmes and codes of practices) and the Government Authorities (legislative measures). In all the cases, the co-operation of the Consumer Organisations/Non-Governmental Organisations (N.G.O.s) is a must.

The legislative measures adopted for food safety are provided under the Prevention of Food Adulteration (PFA) Act- piece of Central Legislation promulgated in 1954 which replaced all earlier Acts of the State Governments.

The Act which came into effect from 1st June, 1955 has been amended thrice, in 1964, 1976 and 1986 for plugging the loopholes and making the punishments more stringent and empowering the Consumers and Voluntary Organisations to play more effective role in its implementation.

Role of Central Government:-

(i) To review the provisions of PFA Act, Rule & Standards in consultation with the Central Committee for Food Standards, a statutory Advisory Committee under the Act and its 9 Technical Sub-Committees.

(ii) To conduct examination for the Chemists for their appointment as Public Analysts under Act.

(iii) To organise training programmes for various functionaries(viz. Senior Level Officers, Chemists, Food Inspector and Consumer Organisations) under the Act.

(iv) To approve the State PFA Rules.

(v) To examine and approve the labels of Infant Foods.

(vi) To evaluate and monitor the progress of implementation of the Act in the States/U.Ts.by collecting periodical reports and spot visits.

(vii) To liaise with National & International Food Quality Control Organisation i.e. B.I.S. (associated with certification of processed food articles), Directorate of Marketing and Inspection operating Agmark Scheme, Ministry of Food Processing Industries, implementation of Fruits Products order (FPO) and Codex Alimentarius Commission.

(viii) To ensure quality of food imported into India, under the provisions of the Act.

(ix) To create Consumer Awareness.

(x) To augment the food testing Laboratries.

Central Food Laboratries:-

Four Central Food Laboratries. have been established under the Act, which work as appellate Laboratries for the purpose of analysis of appeal samples of food articles lifted by the Food Inspectors of States/U.Ts. and Local bodies. The two labs. Viz. (I) Food Research & Standardization Laboratory, Ghaziabad and (ii) Central Food Laboratory, Calcutta are under the Administrative Control of the Directorate General of Health Services and other two viz. (I) Central Food Lab., Pune and (ii) Central Food Lab., Mysore are under the administrative control of Government of Maharashtra and Council of Scientific & Industrial Research, Government of India respectively.

State Food Laboratories:-

There are 81 Food Laboratories under the administrative control of State/U.T. Governments and Local Bodies.

Achievements since the last meeting:-

(I) 14 training programmes have been arranged for Senior level Officers/Public Analysts/Food Inspectors as well as recognised Consumer Organisations so as to acquaint them with the latest developments of the programme of Food Safety and Quality Control.

(ii) An amount of Rs. 1.44 Crores have been released by the Central Government to the State/U.Ts during the year 1995-96 for purchase of equipment by the State Food Laboratories.

(iii) Survey on quality of plastic containers used in food packaging has been carried out with the financial support from W.H.O.

(iv) Survey on presence of pesticide residues in food articles was carried out, which was also supported by W.H.O.

Deficiencies observed

(I) Despite repeated resolutions of the Central Council of Health and Family Welfare, no significant progress has been made in augmenting the infrastructure for the Prevention of Food Adulteration Programme both at the Central and State level.

(ii) It has been observed that samples are drawn generally at the retail level. The State/U.T. authorities need to pay special attention to curb adulteration at source by directing the PFA enforcement machinery to concentrate their attention at the manufacturers'/wholesalers'/distributors' level.

(iii) Efforts are required to be intensified on survey and investigation of source of adulteration from large scale commercial places, like whole-sale/weekly markets/slum areas.

(iv) Strict vigilance needs to be kept on improving quality of street food sold in and around Schools/Colleges/Market places/Fairs/Exhibitions.

(v) Registered Consumer Organisations/N.G.Os need to be actively involved in the programme of food safety and quality control.

(vi) Strong Consumer movement need to be created by holding Radio Talks/T.V. telecasts/Hoardings/Pamphlets etc. Importance of Food Safety and Quality Control needs to be explained to the students of schools and colleges.

(vii) It has been observed that a large number of cases launched under the Prevention of Food Adulteration Act, 1954 by the States/U.Ts generally result in acquittals. The progress of the cases subjudice in various courts need to be monitored at every district headquarter.

(viii) Licensing provisions under the Prevention of Food Adulteration Act/Rules are yet to be enforced in a number of States/U.T.s, though the same is an integral aspect of the food quality and safety programme.

Schemes for improving the Programme under World Bank Funded Capacity Building Project on Food Safety and Quality Control

The following components of scheme are being contemplated for improving the infrastructure at the Central/State level:-

(I) Strengthening of PFA Unit in the Directorate General of Health Services so as to set up a full fledged Secretariat for Central Committee For Food Standards (C.C.F.S.) and National Codex Committee.

(ii) Setting up of three Central Food Laboratories at Kandla, Mumbai and Chennai and zonal offices/import quality control units in Mumbai, Calcutta, Chennai and Chandigarh.

(iii) Augmentation of laboratory facilities of Food Research and Standardization Laboratory, Ghaziabad.

(iv) Augmentation of laboratory facilities at Central Food Laboratory, Calcutta.

(v) Financial assistance to States/UTs for strengthening their Food Testing Laboratories working under the PFA Act, 1954 with staff and equipments under Centrally Sponsored Scheme (100%).

(vi) Setting up of District Food Inspection Units in the States/U.Ts. with management information system providing 100 % central assistance.

(vii) Active involvement of Consumer Organisations/NGOs in the programme by providing financial assistance.

For the purpose of operation of schemes outlined at para (v),(vi) & (vii) above, World Bank has been keen to extend financial assistance for a period of five years provided the States/UTs give commitment to sustain the additional staff created under the project after the period of five years.

Despite repeated persuasion from the Central level, confirmation regarding

sustainabilities has been received only from 13 States/U.Ts namely (1) Andaman & Nicobar Islands (2) Andhra Pradesh (3) Bihar (4) Dadra & Nagar Haveli (5) Delhi (6) Lakshdweep (7) Manipur (8) Mizoram (9) Orissa (10) Pondicherry (11) Sikkim (12) Tamil Nadu and (13) Tripura. Further, States/U.Ts are yet to identify any consumer organisation/NGO who have been contributing effectively towards programme of food safety and quality.

The Council may kindly ensure cooperation from all States/U.Ts for implementation of schemes to be funded by World Bank by confirming their commitment to sustain the additional staff after the project period of five years.

INTRODUCTION OF YELLOW CARD SCHEME FOR COMPULSORY HEALTH CHECK UP FOR SC/ST POPULATION

It is proposed to introduce a scheme for compulsory health check up of SC/ST population in rural areas in the country and to provide them free medical treatment if necessary. This is considered desirable in view of the fact that a large section of these communities continue to remain deprived of the health facilities and do not have access to the facilities provided facilities through the existing outlets. The Government of Karnataka has already launched a scheme known as the Yellow Card Scheme for this purpose. Under the scheme, each member of every SC/ST household would undergo a thorough medical examination annually which would include:

1 Complete physical examination and identifying individuals requiring diagnostic test/ or treatment;

2 Simple laboratory investigation like examination of urine, blood etc. for early detection of diseases if any.

The medical examination would be conducted at health check up camps which would be organised, according to a pre-determined schedule, at the sub-centers or in the villages covered by them for which prior publicity would be given. In order to ensure that each member of the covered population attends the camps, the assistance of the Gram Panchayat Members especially the SC/ST and Women Panchayat Members, will be taken in making a house to house contact to give

publicity and to motivate the officers of the Primary Health Centers concerned and other para medical personnel. Services of the lady medical officers will also be utilised for health check up of women members of the SC/ST households. Cases requiring further examination or treatment would be referred to the nearest Government hospital having the required facilities and such cases would be entitled for free medical treatment on the basis of a referral card issued to them. Although the scheme would be meant for SC/ST population , it would neither be feasible nor appropriate to refuse attendance to the sick persons belonging to non SC/ST households who might turn up at the camps. While such sick persons would also be allowed to avail of the facilities provided in the health check up camps, they would not be entitled to health cards.

The Government of Karnataka had launched the scheme initially in five districts of the State and encouraged by the response and the impact of the scheme, have decided to extend the scheme to the whole of Karnataka. It has been intimated by the Government of Karnataka that the World Bank authorities have also come forward to fund the scheme if it was introduced for covering the most disadvantage sections of the Society in the entire State under the State Health System Project. The scheme could be considered for adoption by other State/UTs also In this connection all States/UTs have been addressed vide the Ministry's letter No.Z.28015/126/96-H dated 7-12-96. The Council may, therefore, consider the issue with reference to the following points:

a. Adoption of the scheme in other States/UTs on a pilot project basis.
b. The likely financial implications of introducing such a scheme and inclusion of the scheme in the State Plans.
c. Whether the existing infrastructure in the Primary Health Centers would be adequate to take up the scheme and necessity of assisting the PHCs by deputing teams from the District.

AMALGAMATION OF STATE HEALTH EDUCATION BUREAU AND I.E.C. BUREAUX

State Health Education Bureaux and I.E.C. Bureaux are working as independent functional units for dissemination of health education, information and creating awareness on different issues of Health and Family Welfare to the masses through existing primary health care approach and utilising the staff posted at the grass-root.

I.E.C. Bureaux are being Centrally funded and they are taking care of messages pretaining to reproductive and Family Welfare aspect where as State Health Education Bureaux are functional on the funds provided by the National Health Programme funds provided by the State Programme officer.

Keeping in view the similarities in the job functions of SHEBs and IEC Bureaux it is suggested that the two kinds of institutions be amalgamated at State/district/block/taluka and PHC levels. This will avoid financial over burdening and optimum utilization of the equipments and existing staff like Mahila Swasth Sangthan, ANM, AWW, BEE, DEMOS, Dy. DEMOS, Nehru Yuvak Kendras and other Medical and Para-medical functionaries placed at the grass-root level.

Health Education provides motivation for self health care and community participation for achieving the goal of health.

RESPONSIBILITIES OF AMALGAMATED BUREAUX

State Health Education Bureaux amalgamated with IEC Bureaux will have to take up the problems of

1. Prevention and control of communicable diseases
2 Life style diseases
3 Reproductive health and child care
4 Health of Adolescent/Youth
5 Malnutrition and Micronutrient deficiency
6 Environmental health and sanitation
7 Occupational health
8 Geriatric health
9 Health related Vocational Courses
10 Health related Research
11 Training of medical and paramedical including NGOs
12 School Health Education
13 Disaster Control and Preparedness programme
14 All National Health Programmes and
15 Any other outbreak/epidemic

DECENTRALIZATION OF THE ACTIVITIES

At present the programmes are conceived at Central level and implemented through the States. It is envisaged that through decentralizing the planning at the local government level and empowering them with financial support IEC strategies shall meet the specific objectives at the grass-root level.

Active community participation delivery requires goals of preventive and promotive health by empowering the community and individual by responsibilities

through proper training, assigning clear cut tasks to be performed with adequate resource backing

COORDINATION WITH OTHER MINISTRIES/DEPARTMENTS

Health Education is a multi disciplinary activity which can be achieved by involvement of various disciplines like youth organisations, school and universities, women organisations, Zila Panchayats, elected bodies at village/town levels and non-governmental organizations; it is desirable and essential that these organisations should be involved and utilized as they have the rapport with the community.

Organisation of Swasth Melas free medical check-up observance of "days"(Pulse Polio, World Health Day, Population Day etc) Child to child approach has proved very useful and effective.

Right age of marriage, spacing between children and one or two norms child can be discussed in the colleges and ANC clinics. Female literacy, socio-economic status of women has great bearing on the health of community, women participation in planning of the programme shall go a long way in successful implementation of the programmes.

Inter-Ministerial resources can be utilised during implementation of programme by coordinated efforts and clear guidelines issued by the respective M inistries for methods to be adopted for implementation of health programmes with special efforts on maintaining healthy environment, inside the home and in the neighbor hood with more stress on proper waste management.

ROLE OF NGOs

NGOs be involved in training, preparation of material and dissemination of health messages

JOB RESPONSIBILITIES AND MATERIAL DEVELOPMENT

IEC material should be programme, area specific and conform to the social and cultural norms. Focal points should be identified for IEC activities at district and State levels.

Job responsibilities of IEC personnel will help in successful implementation of programmes

FINANCIAL AND TECHNICAL SUPPORT

The amalgamated Bureaux shall be 100% Centrally funded and seek guidance and technical support from the Central Health Education Bureau. New Delhi/IEC Bureau, Nirman Bhawan.

PROGRAMMES CONCERNING

INDIAN SYSTEMS OF MEDICINE AND HOMOEOPATHY

EFFECTIVE USE OF ISM&H SYSTEM FOR HEALTH FOR ALL FOR BETTER PATIENTS CARE SYSTEMS

The Indian Systems of Medicine and Homoeopathy (ISM&H) have not received priority in the successive Plan periods. The example of development of Allopathic System in the West has been so overpowering that all the resources available have been channelised for developing an extensive and modern allopathic system. Currently, the Plan Budget for the ISM&H at the Central level is about 3% of the Plan Budget for allopathic system. In the States, it is not substantially different, while there is some variation from State-to State. With these inputs, the ISM&H systems cannot develop and the facility of ISM&H treatment cannot be made available to people at a competent level. However, at the National level, a new Department of ISM&H has been created in 1995 and since the Ninth Five Year Plan is beginning in 1997-98, this is an opportunity for restoring some priority to ISM&H sector and to redress some of the accumulate deficiencies in these systems.

The large number of practitioners (6 lakhs) of ISM&H traditional health promotional practices and readily assessable medicinal material of ISM need to be utilised in National Health Care delivery system. Various NGOs and State Governments are required to play active role. The Department of ISM&H and Government of India also intend to support partially various schemes in this regard.

ISM&H treatment facilities at Block Level

There are 23064 ISM&H dispensaries in the country. But these are not uniformally distributed at a certain level of village throughout the country. It is

difficult to cover all the 5 lakh villages of the country by providing them a unit of ISM&H dispensary. Therefore it is proposed to cover all the Block head quarters by providing an ISM&H dispensary with the necessary infrastructure. This block level centre will coordinate all the activities relating to ISM&H in the block.

District level Hospital of ISM&H

Out of 500 districts in the country only one hundred are having indoor facilities of ISM&H. All the districts need to have an indoor and out door ISM&H facilities of 30 beds which will include specialised treatment like Panchakarma, Kshar-Sutra and Child and Mother Care facilities in ISM&H lines. These district hospitals will serve as referral centres for ISM&H therapies.

Central Government Health Scheme Dispensaries

ISM&H facilities are available in 74 dispensaries/units whereas allopathic treatment facilities are available in 242 dispensaries in the country. As per the spirit of the scheme Ayurveda, Unani, Siddha, Homoeopathy and Yoga Units needs to be extended in the remaining 168 CGHS dispensaries in the country. In this way Delhi and all other major cities will have ISM&H facilities.

NGO Hospitals of specialised treatment of ISM&H

Government alone cannot make available specialised ISM&H Hospital in the country. NGOs will be supported to establish 1-2 (50 bedded) specialised treatment hospitals in each State. NGO/Societies will be supported upto the extent of 80% for a plan period to establish these hospitals on chargeable basis.

Upgradation of ISM&H Educational Institutions for improving standards.

About 80% teaching institutions of ISM&H do not fulfil the norms/standards of Central Council of Indian Medicine and Homoeopathy.

Financial constraints are the main reasons. Even the State Government institutions are not following the CCIM norms. Therefore, States and Central Governments need to allocate sufficient resources and take up ISM&H as a priority item to produce trained ISM&H practitioners.

Unified Educational Authority for ISM&H

There is no competent regulatory and funding body like UGC to support ISM&H education. Therefore it is highly necessary to establish a unified education authority for ISM&H, through appropriate legislation which could finance and monitor the educational standard of ISM&H. Sufficient funds also need to be provided to this body for creating the required infrastructure as per CCIM/CCH norms.

Training to the Para-Medical Personnel

Therefore, the training institutions of Pharmacists/Nurses and Technicians need to be supported by the State and Central Governments.

Strengthening of Eminent ISM&H Graduate Colleges of Yoga and Naturopathy.

Faculty of Ayurdeda, BHU, National Institute of Ayurveda, Jaipur, Institute of PG Studies Jam Nagar, Hamdard University, Delhi, Aligarh Muslim University and National Institute of Homoeopathy, Calcutta need to be strengthened to develop as eminent institutes of ISM&H. Similarly some existing yoga institutes like Vivekanand Kendra, Bangalore, Kaivalya Dham Samiti, Lonavala and Bihar School of Yoga, Munger will be assisted for graduate level courses of Yoga.

Various reorientation training programmes for ISM&H professionals need to be taken up to update the skill of ISM&H professionals.

Research and Development Proposals

Existing units of various Research Councils i.e. CCRAS, CCRUM, CCRH need to be consolidated to manageable number (25% of the existing total number). Construction of buildings and provisions of the proper man and materials is the priority for proper functioning of these research councils. Specific in-house research in a time bound manner on diseases and treatments of National priority, more in the areas where the existing allopathy do not have the proper answer. There is need for research on minerals, metals, marine and animal products extensively used in ISM&H. Collaborative research with the other institutions is a right step to accelerate the research activities relating to ISM&H.

Development of Medicinal Plants and other Raw materials used in ISM&H

The requirement of ISM&H plants/material is increasing and traditional source of forest area is getting reduced. To ensure the quality medicine, conservation, propagation of medicinal plants is very necessary. The following steps have been proposed:-

(i) Development of Agro techniques of various medicinal plants;
(ii) Establishment of Medicinal plants garden;
(iii) Establiishment of "Vanaspati Van" in the denuded forest areas.
(iv) Setting up germ plasm banks
(v) Publicity of common use of these medicinal plants in health care and their cultivation practices.

Development of Pharmacopoeia and Drug Testing Laboratories of ISM&H

Pharmacopoeia of Ayurvdea, Siddha and Unani Drugs need to be developed on priority for strengthening of existing Indian Pharmacopoeial Laboratories of ISM&H. Similarly State and Central Governments need to support the establishment of State Drug testing Laboratories which is also necessary to implement the Drug Act provisions.

Strengthening of IMPCL and State Pharmacies of ISM

IMPCL, Mohan, a public sector undertaking of Government of India and UP Government is producing medicines worth of Rs. 2 crores per annum approximately to provide quality medicines. The strengthening of IMPCL and other State Pharmacies by providing them assistance to update their infrastructure is very necessary.

Intellectual Property Right Cell of ISM&H Medicines

In the present scenario of WTO and GATT it is necessary to set up a patent cell which could take care of interest of patentable ISM&H researches.

The ISM&H sector is expected to receive higher priority in 9th Plan. While the Government of India will attend to the remaining areas in a substantial manner, the treatment facilities and ISM&H colleges will have to be the concern of the State Governments. The ISM&H treatment facilities presently suffer from lack of buildings, infrastructure, non-sanction of doctors catering to different branches of ISM disciplines and lack of medicines. The State Governments may take this opportunity and provide adequate funds for improving the ISM&H treatment facilities and ISM&H colleges in the Ninth Five Year Plan.

ROLE OF ISM&H DISPENSARIES (GOVERNMENT SECTOR) IN NATIONAL HEALTH CARE DELIVERY SYSTEM.

There are 23064 dispensaries in Government sector rendering ISM&H facilities to the people. They are situated in far flung areas mainly at Gram Panchayat or Village level. These are generally housed in two-rooms accommodation. One Physician, one Pharmacist, one Class IV is the staffing pattern for these dispensaries. Annual quantum of medicines ranges from Rs. 4000 to Rs. 40,000. These ISM&H physicians are providing medical care facilities in routine ailments as well as in emergency conditions. The total number of patients attended through these dispensaries is quite significant which shows the popularity and acceptance of these indigenous physicians.

These dispensaries have following problems in their functioning :

(i) Lack of proper building and accommodation to have the dispensary and doctor in majority of the dispensaries in the country. For example in the State of Himachal Pradesh, out of 650 dispensaries, only about 150 have got accommodation, in the remaining either one or two rooms are donated by Panchayat or local people. There is no provision of residential accommodation for doctors. As a result the doctors are not available round the clock. In the State of Rajasthan, out of 2700 dispensaries of ISM&H 80% are running in donated one or two rooms accommodation. The patient carry poor impression while getting service in a totally unimpressive dispensary.

(ii) The medicines supplied to ISM&H dispensaries are totally inadequate in majority of the dispensaries. The annual expenditure ranges from

Rs. 4000 to 10000/- per year. Only a couple of States provide medicines worth Rs. 20,000-40,000. In remote areas only the Government supply is the source of medicines. Therefore, the shortage of medicines is a general problem. In a large State like Uttar Pradesh where the number of Ayurveda dispensaries and hospitals is 2207, there is no supply of medicines for the last two years due to administrative problems and the ISM&H doctors are sitting idle for want of medicines.

(iii) The problem of availability of doctors of modern system in the rural areas is wellknown. Because of non-availability of allopathic doctors, dispensary facilities created at considerable cost remain unutilised and on the one hand, the investment made by the state governments remains infructuous, on the other hand, the facility of treatment to public is not available. It is worth considering in this context that ISM&H sector does not suffer from this problem. If dispensaries below block level are converted into wholly ISM&H dispensaries, adequate infrastructure at no additional cost will become available by ISM&H dispensaries. The ISM&H doctors will willingly go to such places. In addition, the public will be able to receive facility of treatment under ISM&H. The State Governments will have to transfer the financial provision for such dispensaries to ISM&H sector and convert the post of allopathic doctors into ISM&H doctors. The Central Council may consider this suggestion.

INDIAN SYSTEMS OF MEDICINE AND HOMOEOPATHY MEDICAL COLLEGES

The Government of India has set up the National Institute of Homoeopathy at Calcutta, National Institute of Ayurveda at Jaipur and National institute of Naturopathy at Pune. While the first two institutions are reasonably well provided, the NIN is being taken up for creating infrastructure facilities now. National institute of Unani System is being set up at Bangalore and it is proposed to set up National Institute of Siddha at Madras and National Institute of Yoga at Delhi soon. These National Institutes will provide leadership in terms of standards and facilities in their respective disciplines. For Yoga, the Government of India is planning to assist some eminent non-Governmental organisations for starting a four year degree course.

In the country, there are 118 Ayurveda colleges, 30 Unani colleges and 130 Homoeopathy colleges. However, the facilities in these colleges are generally poor. Many of them are running in a few rooms and a large majority of them do not fulfil even the minimum norms laid down by Central Council of Indian Medicines and Central Council of Homoeopathy. What is more unfortunate is that many of the Government colleges suffer from such marked deficiencies. Admissions to these colleges are now through a combined entrance test in which generally students who do not get selected for the modern system are channelised for admission to ISM&H colleges. This results in too many students having no aptitude for ISM&H being forced into these disciplines and many of them either try to leave these colleges after one or two years or do not show interest in studies.

Many of the ISM&H colleges do not even care to apply for recognition to the CCIM/CCH in time. Some of them apply many years late and then exert pressure on the Councils on the plea that the interest of the students will be hurt. For example, Yashwant Shikshan Mandal Ayurvedic Mahavidyalya, Kadoli, was set up in Sept., 1989 and applied for recognition only in June, 1993. Same was the case of Ayurvedic Mahavidyalaya set up by this institution in Kolhapur. Caitanya Ayurvedic Mahavidyalay, Bhusawal also was set up in 1989 and applied for recognition only in May, 1993. Mai Bhago Ayurvedic Mahavidyalaya Muktsar was set up in 1975 and it applied for recognition in Feb., 1976. Similarly, in Unani system, Jamia Tibia (UP) was set up in 1987 but applied for recognition in October, 1990. Ibne Sinha Tibbi College, Azamgarh (UP) was set up in 1980 but applied for recognition only in March, 1992. And Institute of Medical Sciences, Srinagar (J&K) was set up in 1993 but it applied for recognition in Sept., 1994. These are only some of the illustrations, the actual phenomenon is more pervassive. The State Governments should see to it that no unrecognised college starts admissions and similarly if a college has been derecognised, it no longer continues to admit students. The Government of India is considering amendments to the IMCC Act and CCH Act to provide penal powers for such cases.

The State Governments are also requested to ensure observance of the norms laid down by CCIM/CCH both in private and Government colleges. There is need to urgently improve supervision of the functioning of such colleges.

In some States, the posts of teachers in ISM&H colleges are interchangeable with those of doctors in dispensaries. This adversely affects the quality of teaching because those who have aptitude for studies alone made good teachers. The State Governments where such transferability exists need to separate the cadre of teachers without delay. In regard to the admission of students, a joint entrance examination needs to be given by, because the experience shows that it is feeding indifferent and substandard students into the

ISM&H Colleges. There are some students who are interested in ISM&H and obviously admission must be made out of them only. In ISM there is another special requirement that is for Ayurdeda, knowledge of Sanskrit has to be acquired and the students must have a healthy respect for the traditions. In Unani system knowledge of Urdu and persian has to be acquired. Such student groups are quite distinct from the group that aspires to be doctors of modern system. Therefore, the Central Council may consider recommendations to the State Governments that admission tests for ISM&H colleges should be separate so that only students who have interest in these disciplines and who have aptitudes for these disciplines alone appear in the examinations and get admitted. In such admission tests will also be worthwhile to agree to prescribe that only those students who have done higher secondary with science are considered eligible for these courses because without science background no body can be a good doctor in any of the ISM&H disciplines. Students who have done higher secondary only with Sanskrit or Urdu/Persian are apparently not suitable, if they have not offered science also. The colleges will of course then make arrangements for extensive study of Sanskrit during 4 1/2 years in Ayurveda and of Urdu/Persian for Unani. These measures will improve the management and standards of education in ISM&H colleges which in turn will turn out good graduates who will be attuned to the ISM&H standards and will be able to contribute to their development. It needs to be realised that the present arrangement is leading to poor standard of education in ISM&H colleges and poor quality of graduates coming out of the system are neither leading to deliver competent medical service to the citizens nor to the development of ISM&H disciplines.